United Republic of Tanzania
Ministry of Health, Community Development, Gender, Elderly and Children

Implementation Guidelines
for Health Facility–Based Distribution of LLINs

September, 2016

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I. Overview of Health Facility Based Distribution of Long-Lasting Insecticide-Treated Nets

In a program widely known as the Tanzania National Voucher Scheme or "Hati Punguzo," which ran in the Tanzania mainland from 2004–2014, pregnant women accessing antenatal care (ANC) services and children receiving immunization services were able to obtain long-lasting insecticide-treated nets (LLINs) through health facilities. To ensure that these biologically vulnerable groups continue to have access to LLINs, the Government of Tanzania plans to reintroduce LLIN distribution in health facilities. This program will be different from Hati Punguzo in that the new model will distribute LLINs in health facilities to the intended beneficiaries directly, without the need for a voucher or co-payment. The guidelines presented here were drafted to clarify and communicate this new setting to all involved partners.

The distribution of LLINs through health facilities is part of a broader National Insecticide Treated Nets (NATNETS) strategy to ensure that LLIN coverage in Tanzania is sustained at 85% and above. In this program, LLINs will be distributed through ANC and Immunization and Vaccine Development (IVD) program service delivery. Other elements of the NATNETS strategy include mass LLIN distributions, LLIN distribution through schools and commercial LLIN sales.

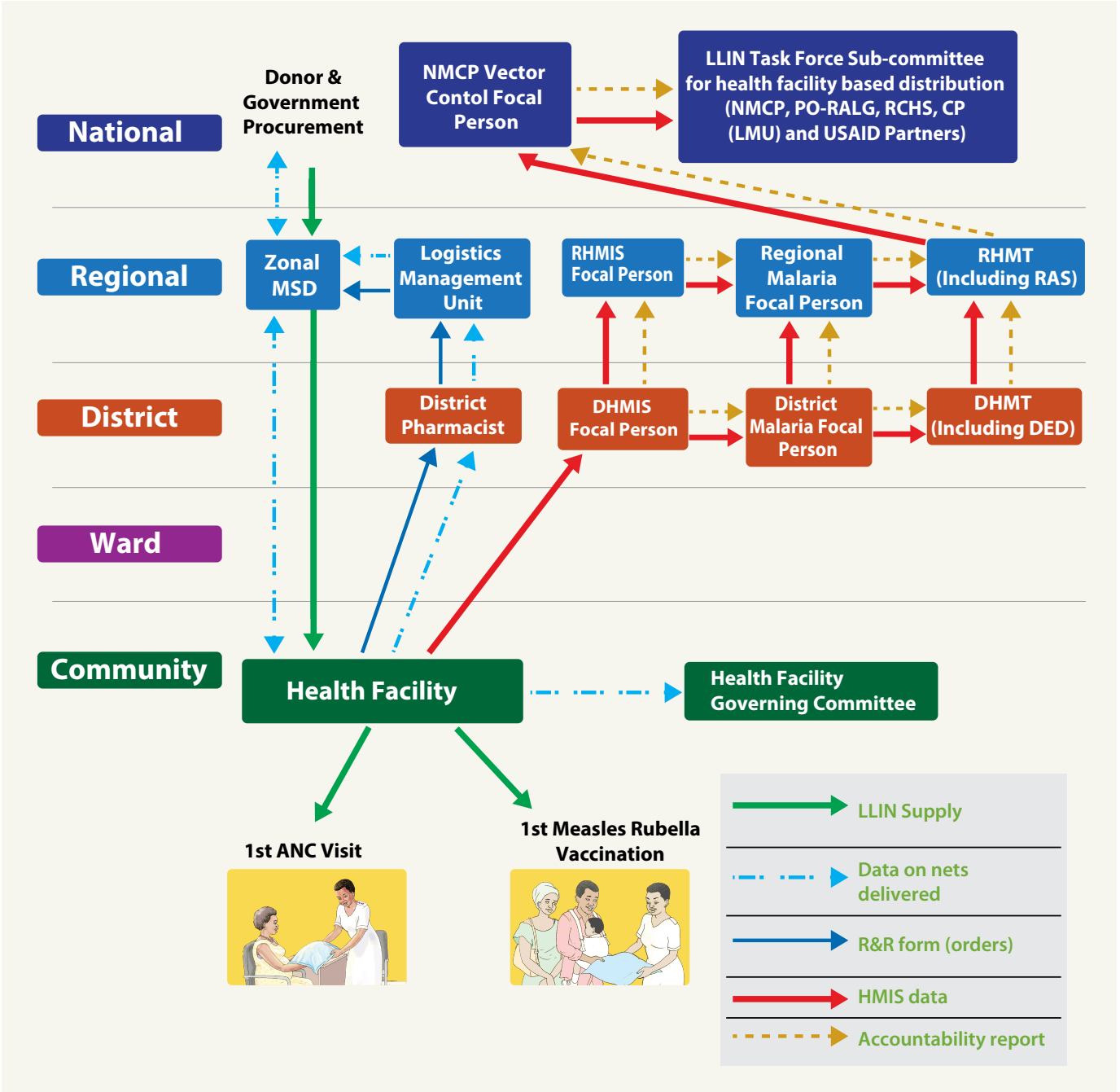
For health facility–based distribution, a pregnant woman will receive a free LLIN during her first ANC visit for each pregnancy. LLINs are provided during the first ANC visit to ensure that the benefits of protection to mother and unborn child begin early in the pregnancy.

Similarly, a child receiving a first measles vaccination at a vaccination clinic or during outreach services will get a free LLIN to ensure that the child's sleeping space is covered, particularly when infants are no longer sleeping with their mothers. Health facility workers will therefore be required to carry LLINs along for their regularly scheduled outreach visits to communities.

With a view toward sustainability and cost-effectiveness, the health facility–based LLIN distribution program will use existing government structures and systems as much as possible. An accountability reporting system will be introduced as an additional component to ensure effective accountability for LLINs supplied and distributed and to maintain transparency at all levels, from the national and regional levels down to the health facility level.

The flow of LLINs, data and reports for the health facility–based LLIN distribution is summarized in Figure 1 below.

Figure 1:
Flow of LLINs, Data and Reports for Health Facility–Based Distribution



Note: *Pink boxes are the parties focused on LLIN transport, LLIN issuing, and report and requisition (R&R) reporting. Blue boxes are the parties focused on Health Management Information System (HMIS) reporting and accountability.*

As shown in Figure 1 above, the flow of LLINs and distribution data is as follows:

- LLINs procured by donors through identified procurement agencies will be transported directly from the manufacturer to Medical Stores Department (MSD) zonal warehouses and then further transported to health facilities (blue arrows).
- Health facility workers will issue LLINs to pregnant women on their first ANC visit for that pregnancy and also to children receiving the measles vaccine (blue arrows).
- The number of LLINs issued to these beneficiaries will be reported to higher levels using the standard **Health Management Information System (HMIS)** (black arrows).
- Health facilities will request resupplies of LLINs using the standard **report and requisition (R&R) form (Appendix I)** (red arrows), and these requests will follow the existing reporting schedule.
- Health facilities' orders for LLIN resupply will be checked by the facility's District Pharmacist, entered into the Electronic Logistics Management Information System (eLMIS), and then checked by the Logistics Management Unit (LMU) at the zonal level. The quantities of LLINs approved for resupply will then be released by the MSD zonal warehouse (red arrows) and transported to a designated health facility by a contracted transporter or the MSD.
- Health Facility Governance Committees (HFGCs) will review the number of LLINs supplied to health facilities and sign the **proof of delivery/MSD sales invoice (Appendix III)**.

Also, for effective oversight and accountability of LLIN supply and distribution, the following accountability reporting system will be used (as shown in Figure 1 above with purple arrows):

- The District Malaria Focal Person will compile monthly and quarterly LLIN accountability reports for each health facility based on initial numbers of LLINs supplied, requests for LLIN resupply, and number of LLINs issued to beneficiaries as reported in the eLMIS and HMIS.
- The District Malaria Focal Person will compile monthly and quarterly district LLIN accountability reports **(Appendices XI and XII)**, which will be aggregations of the health facility reports.
- The reports will be shared with the District Medical Officer (DMO) and the District/ Council Director. Detected variances in the monitored LLIN and service delivery variables will be flagged in LLIN accountability reports for follow-up and further investigation.

- The DMO will present the LLIN accountability reports to the Council Health Management Team (CHMT) during their monthly meetings, and together they will decide on a plan of action for the health facilities with detected variances. Both the DMO and the District/Council Director will be responsible for ensuring that all variances in the LLIN accountability reports are investigated and resolved satisfactorily.
- The Ward Executive Officer (WEO), the Village Executive Officer (VEO) and the HFGC will support investigations of variances in health facility distribution; for hospitals, the Hospital Management Team and Hospital Services Board will be responsible for ensuring that all variances are investigated and resolved.
- The LLIN accountability reports, along with actions taken at the district level, recommendations and/or requests for additional support for implementation (where needed), will be shared with the Regional Medical Officer (RMO) and the Regional Administrative Secretary (RAS) by the DMO and the District/Council Director.
- The Regional Malaria Focal Person together with the Regional Pharmacist will review the district LLIN accountability reports and then aggregate them into a regional level report. The regional level report will be reviewed during Regional Health Management Team (RHMT) meetings with the RAS (or a representative).
- Updates on health facility–based LLIN distribution and the action items will be presented and discussed during RHMT and CHMT meetings.
- The regional LLIN accountability reports will be submitted by the Regional Malaria Focal Person to the National Malaria Control Program (NMCP) for review and will be shared during the LLIN Task Force meetings.

The following sections describe the planning and coordination process; logistics and supply chain management, including LLIN quantification, supply and resupply; training and orientation; documentation and reporting; accountability; monitoring and supervision; social and behavior change communication (SBCC); and budgeting for health facility–based LLIN distribution in Tanzania.

II Planning and Coordination

At the national level, the LLIN Task Force will convene meetings to plan and coordinate health facility–based LLIN distribution activities. Participants of these meetings should include the following key players:

- Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC): NMCP, Reproductive and Child Health [RCH], MSD, Pharmaceutical Services Section, Health Information Section, Planning Department and Health Education Unit.
- President's Office, Regional Administration and Local Government (PORALG): Department of Health and Social Welfare, and Nutrition and Sector Coordination Department.
- Development partners and donors: President's Malaria Initiative; the U.K. Department for International Development; and the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Other relevant implementing partners, including NGOs and private sector representatives: Johns Hopkins University, Population Services International, Tanzania Center for Development Communication, Tanzania Red Cross Society, etc.

For effective monitoring and oversight of activities at all levels, the LLIN Task Force will form a subcommittee for health facility–based LLIN distribution, with representatives from organizations as listed above. This subcommittee will be solely responsible for effective implementation of all health facility–based distribution activities at the national level.

At the regional and district levels, similar planning and coordination meetings should be held for health facility–based LLIN distribution. Coordination committees will be formed based on existing committees for planning and implementation of health interventions at regional and district levels. The regional level coordination committee will be composed of the existing RHMT and CHMT, the RAS and relevant representatives from the RAS's office, and personnel from other relevant units and divisions at the regional level. At the district level, teams and personnel of similar authority and responsibility as at the regional level will form the district level coordination committee The coordination committees at the national, regional and district levels will be responsible for the overall planning, coordination, implementation, monitoring, and supervision of health facility–based LLIN distribution and will also provide technical support for effective implementation. Specific terms of reference for the coordination committees should be developed.

Focal persons for the various aspects of implementation (e.g., logistics and supply chain management, training, monitoring and supervision, data collection and reporting, and SBCC) should be part of the coordination committees at each level. These focal persons will lead and coordinate relevant aspects of the health facility–based LLIN distribution and will report regularly to the larger committee. Periodic statutory meetings will be convened by the regional and district coordination committees to review LLIN distribution data and discuss implementation issues.

The planning and coordination process should involve key stakeholders from national to council level. The following issues should be discussed by planning and coordination committees at all levels to ensure smooth implementation of LLIN distribution:

- LLIN quantification (as described in the quantification section below), procurement, and supply
- Trainings and orientations of personnel at all levels
- Effective monitoring and supervision of LLIN distribution activities
- Review of existing and newly developed tools for data collection, monitoring and supervision, and accountability for LLIN distribution
- Planning and review of implementation timelines for all activities
- Advocacy and sensitization of leaders and implementers at all levels
- Availability of resources to ensure uninterrupted LLIN distribution
- Political will and commitment at all levels
- Accountability and good governance
- Roles and responsibilities in the management and distribution of LLINs

III Logistics and Supply Chain Management

The core functions of LLIN logistics management (quantification, procurement, ordering and distribution) will follow the same procedures as those of other national health commodities supplied by MSD.

A. Quantification of Annual LLIN Needs

i. Type of data required

Prior to the quantification exercise, various data pertaining to pregnant women and to children who received measles vaccination should be collected and analyzed. Specifically required is the data listed below:

- Health service statistics data
  - o Number of women of childbearing age—census/HMIS data
  - o Number of pregnant women—census/HMIS data
  - o Number of pregnant women who completed an ANC visit for the first time—HMIS data for at least the past 2 years
  - o Number of children who received first dose of measles
  - o HMIS data for at least the past 3 years
- LLIN issuance data if applicable—MSD data
- LLIN consumption data if applicable—eLMIS/survey data
- LLIN stock-on-hand data if applicable—eLMIS and physical inventory data
- LLIN quantities on order if applicable—pipeline data

ii. Frequency of quantification and reviews

The MoHCDGEC through NMCP will lead the process of quantification in collaboration with RCH and IVD. LLIN quantification should be based on a bottom-up approach in which districts submit their LLIN quantification data for health facility distribution to the regional level for validation. The validated and aggregated district quantifications will be submitted to the national level as the region's LLIN quantification. This process will be conducted on an annual basis with forecasts for 1 year, and a review will be held every 6 months.

iii. Tools used to support quantification and monitoring

- *NetCalc* – based on population
- Pipeline monitoring – managed by MSD and NMCP

B. Procurement, Ordering and Distribution

LLINs will be procured by development partners and MoHCDGEC through NMCP and MSD. LLIN storage and distribution will be done by the MSD through the existing system.

i. Procurement

To ensure that LLINs are continuously available for distribution, the procurement process should begin at least 1 year in advance (i.e., the procurement process for LLINs for 2017 should start in 2016). Quantities of LLINs to be procured can be estimated using available data for ANC and immunization service delivery and computed based on averages for at least the past 2 years.

Funding for LLIN distribution in Tanzania currently depends on donor funding cycles. Funding should be guaranteed at least 1 year ahead of the LLIN procurement process. Funding partners will therefore be required to plan and commit funds in advance to ensure continuous availability of LLINs. LLINs should be procured through an agreed government- or donor-selected procurement agency.

All LLINs procured to be used in Tanzania should be in line with the World Health Organization Pesticide Evaluation Scheme recommendations and registered with the Tropical Pesticides Research Institute.

ii. Ordering system for LLINs

The supply of LLINs to health facilities will be through the Integrated Logistics System (ILS) and will follow the health facilities' existing ordering schedules.

To ensure that the flow of LLINs from the zonal level to the health facility level is uninterrupted, the stock to be held at each level will be as follows:

- **MSD at zonal level:** Minimum 6 months and maximum 9 months
- **Health facility level:** Minimum 3 months and maximum 6 months

a. Initial LLIN supply

The initial supply of LLINs to health facilities will be done by a "smart push" approach, where each health facility will be provided with their initial required 6-month supply of LLINs. Consignments of LLINs will

be distributed to health facilities by the MSD and a private contracted logistics company. The quantities of LLINs to be supplied to each health facility will be determined and approved by NMCP.

b. Subsequent supply and restocking

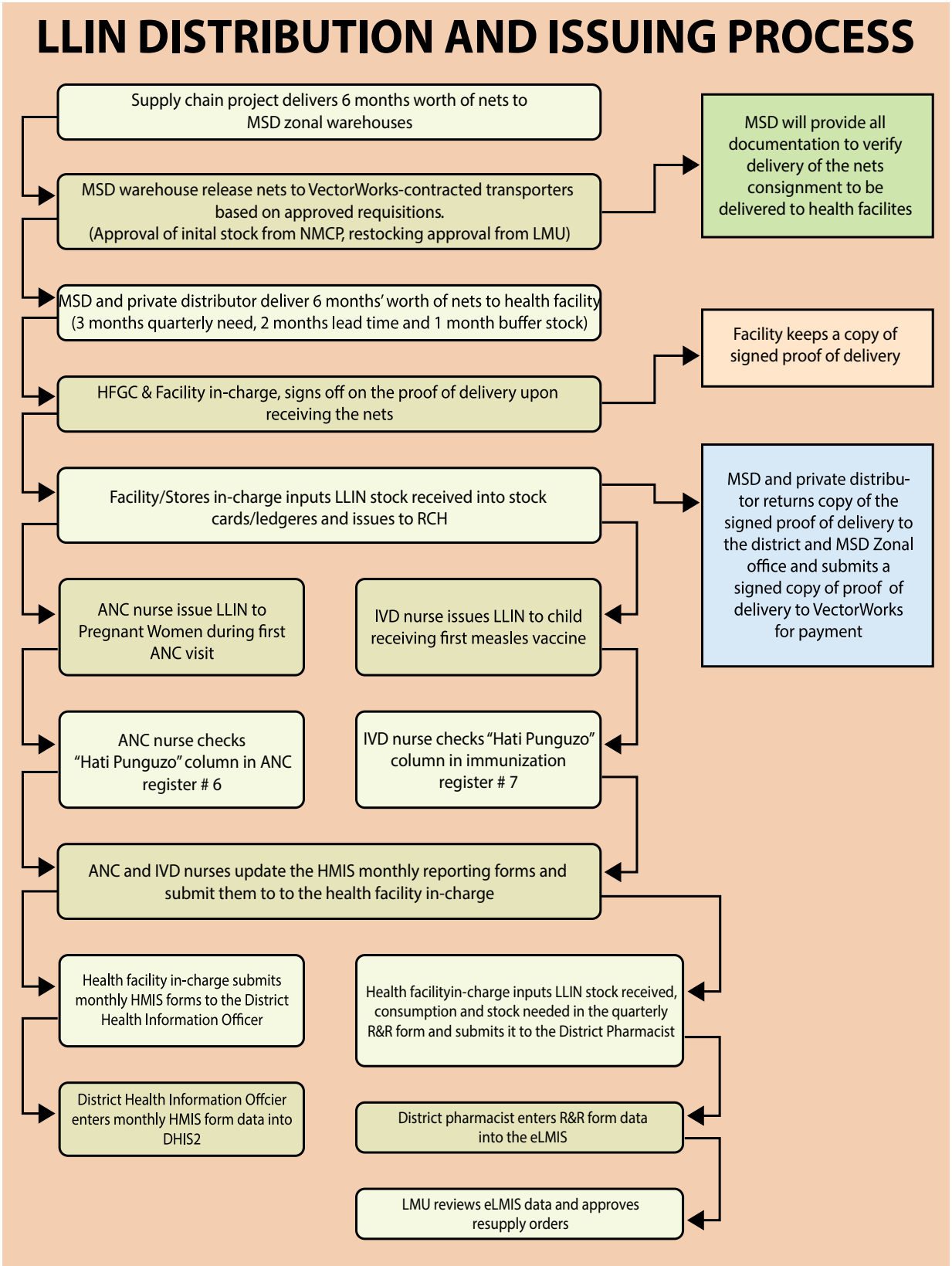
After the smart push, orders for resupply will be driven by demand through a health facility quarterly ordering system using the ILS R&R form. This system allows each health facility to start ordering immediately according to their respective group ordering schedules (A, B and C). In cases of health facility stockouts before a scheduled ordering period, the Health Facility In-Charge will alert the District Pharmacist, who will then communicate with MSD zonal warehouse for an emergency supply.

iii. Receiving of LLINs at health facility

Receipt of LLINs at the health facility requires the presence of both the Health Facility In-Charge and the HFGC, who will verify the quality and quantity of LLINs supplied. Documentation of LLINs received will be done in the health facility ledger/stock card (Appendix II), which will capture the quantity received, date of receipt and MSD invoice number. After that, the proof of delivery/MSD sales invoice (Appendix III) will be signed and returned to the MSD for documentation. In case of a mismatch of actual quantity of LLINs received at a health facility with the quantity quoted on the MSD sales invoice, the Health Facility In-Charge will fill in a claims form (Appendix IV) and submit a copy to the MSD and the contracted transporter.

Figure 2 shows the overall distribution process from LLIN supply at the zonal level to receipt and resupply requests at the health facility level.

Figure 2.
LLIN Distribution and Issuing Process

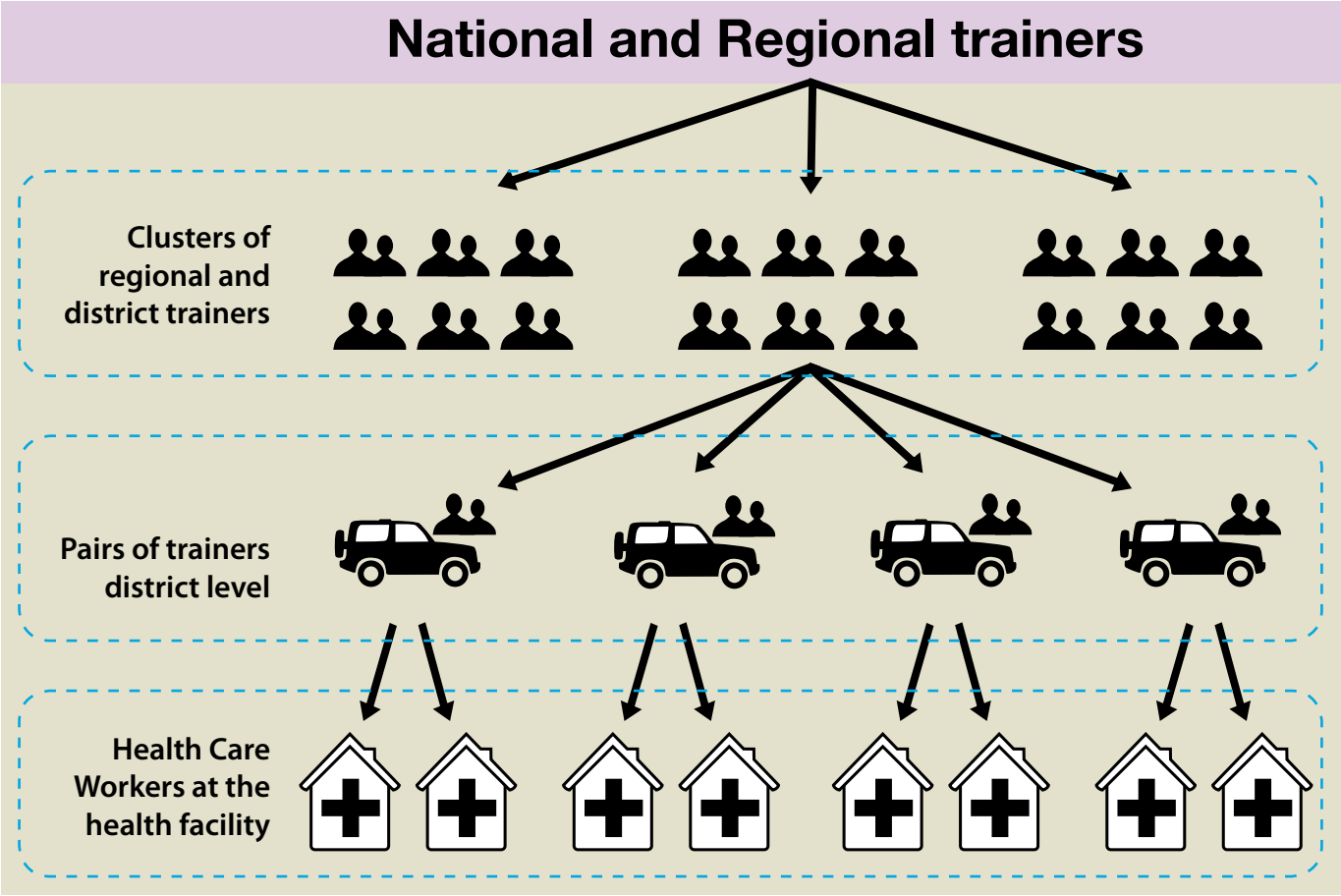


IV Training and Orientation

Trainings and orientations for health facility–based LLIN distribution should focus on operational issues. Specifically, it is important that Health Facility In-Charges, storekeepers, and health workers in ANC and IVD clinics are well trained in the processes for receiving LLIN stocks and requesting restocking based on agreed LLIN stock thresholds. Also, it is important that health workers at ANC and IVD clinics are well versed in proper documentation in clinic registers of LLINs issued to beneficiaries, reporting monthly summaries of LLINs issued, and educating beneficiaries on malaria prevention and proper care for LLINs.

Figure 3 shows the structure of trainers and facilitators from the national to health facility level.

Figure 3:
Training Model



The following trainings/orientations should be conducted to ensure that LLIN distribution, documentation and reporting is well done:

National Level

A team should be formed of national level trainers from the MoHCDGEC (NMCP, RCH, Pharmaceutical Services Section, PORALG, MSD, Health Education and Promotion Unit) and implementing partners. National level trainers should themselves be trained on the following:

- Background and rationale for LLIN continuous distribution
- Process for quantifying LLINs at the national level available for health facility–based distribution in all regions
- Proper use of stock cards for documenting LLIN supplies and stocks on hand
- Use of clinic registers for proper documentation of LLINs issued to beneficiaries in health facilities
- Use of monthly HMIS summary forms for reporting LLINs distributed in health facilities
- Use of R&R forms for reporting LLINs received and issued at health facilities and for requesting resupply
- Reorientation on malaria prevention and LLIN use, repair and care messaging
- Proper accountability of LLINs supplied to health facilities via the LLIN accountability reporting system, for focused and effective monitoring
- Roles and responsibilities for stakeholders at all levels

The national level trainers should also be trained on how to conduct effective monitoring and supervision of health facilities for LLIN distribution and how to use relevant checklists for monitoring and supervision visits.
Training of national-level trainers should not take more than 1 day.

Regional and District Level

The national level trainers will facilitate trainings for regional and district personnel. All relevant personnel from the regional and district levels should attend, including members of the regional and district technical teams and especially the IVD officers, zonal level MSD officers, LMU officers, RCH officers, pharmacists, malaria focal persons, and HMIS focal persons and health officers from both regional and district levels.

Regional and district level facilitators should be trained on the following:

- Background and rationale for LLIN continuous distribution
- Process for quantifying LLINs for health facility–based distribution for all districts in a region
- Proper use of stock cards for documenting LLIN supplies and stocks on hand
- Use of clinic registers for proper documentation of LLINs issued to beneficiaries in health facilities
- Use of monthly HMIS summary forms for reporting LLINs distributed in health facilities
- Use of R&R forms for reporting LLINs received and issued at health facilities and for requesting resupply
- Reorientation on malaria prevention and LLIN use, repair and care messaging
- Proper accountability of LLINs supplied to health facilities via the LLIN accountability reporting system, for focused and effective monitoring
- Roles and responsibilities for stakeholders at regional, district, village and health facility levels

Regional and district facilitators should also be trained on how to conduct effective monitoring and supervision of health facilities for LLIN distribution and how to use relevant checklists for monitoring and supervision visits.

District personnel present at the training shall also be required to develop a training schedule for on-the-job trainings in all health facilities in their districts, together with a follow-on monitoring plan. Each district shall present its plans to all participants present for further review and input. The regional personnel present shall take note of the districts' plans and also plan to support the district personnel in trainings and monitoring of health facilities.

There should be no more than 30 participants in each training session. Based on the number of regional and district personnel to be trained, there may be a need to conduct more than one session of training in each district. These trainings should be conducted over 2 days.

Health Facility Level

A team of two trained personnel from the district and regional levels will visit each health facility to provide an on-site on-the-job orientation session for all health facility personnel. These orientations will be supported and supervised by trained facilitators from the regional and national levels. HFGC and Village Health Committee (VHC) members should also be included in the orientations at health facilities. Note that the on-site training teams should not consist of the same cadre/profession (i.e., a Regional Pharmacist should not join a team with a District Pharmacist).

The content of the health facility on-the-job orientation sessions should include the following:

- Rationale for LLIN continuous distribution and the eligibility criteria for beneficiaries
- Proper use of stock cards for documenting LLIN supplies and stocks on hand
- Use of clinic registers for proper documentation of LLINs issued to beneficiaries
- Use of monthly HMIS summary forms for reporting LLINs distributed
- Use of R&R forms for reporting LLINs received and issued and for requesting resupply
- Interpersonal communication and counseling on malaria prevention and LLIN use, repair and care
- Ways to sensitize communities about ANC and vaccination service utilization, health facility–based LLIN distribution, and malaria prevention
- Roles and responsibilities of health workers and HFGC and VHC members in ensuring security and accountability for LLINs

The on-the-job orientations should be practical and should refer to the available registers and tools at the health facility. Each session should be no longer than half a day for each health facility.

To ensure that trainings are standardized, a step-by-step training manual should be developed for all trainers and facilitators to use. The training manual should be highly participatory with visuals and practical sections.

V LLIN Issuing, Documentation and Reporting

Health facilities will use the existing health facility registers and monthly HMIS summary forms the document and report numbers of LLINs issued.

During a pregnant woman's first ANC visit, the health worker should do the following:

- Go through all the usual steps for a first ANC visit.
- Educate the pregnant woman on the causes of malaria, malaria prevention, the proper use, repair and care of the LLIN, and the need for prompt testing and treatment.
- Provide an LLIN to the pregnant woman and place a check mark (N) in the "Hati Punguzo" column in the **ANC register (HMIS # 6; see Appendix V).**
- Sign and date the **pregnant woman's antenatal card (Appendix VI)** in the space for "Hati Punguzo."

Note: *The current ANC register does not have a column for recording distribution of an LLIN. Health workers should be trained to place a check mark in the column labeled "Hati Punguzo." Future revisions of the register should relabel this column "LLIN distributed."*

Similarly, when a caregiver brings a child to the IVD clinic or conducts outreach for a measles vaccine, the health worker should do the following:

- Go through all the usual steps for routine measles immunization and record all the required information in the **Under 5 register (HMIS # 7; see Appendix VII)**.
- Educate the caregiver/guardian on the causes of malaria; malaria prevention; the proper use, repair and care of the LLIN; and the need for prompt testing and treatment.
- Provide an LLIN to the caregiver/guardian and place a check mark (N) in the "Hati Punguzo" column in the **Under 5 register (HMIS # 7; see Appendix VII)**.
- Sign and date the **child's immunization card (Appendix VIII)** in the space for "Hati Punguzo."

Note: ***The current Under 5 register does not have a column for recording distribution of an LLIN. Health workers should be trained to place a check mark in the column labeled "Hati Punguzo." Future revisions of the register should relabel this column "LLIN distributed."***

At the end of each month, each health facility should tally the total number of LLINs issued in the facility's ANC and IVD clinics (both static and outreach) and record it in the **monthly HMIS summary form for ANC (Appendix X)** and the **monthly HMIS summary form for Under 5 (Appendix XI)**. The summary forms should be submitted by the Health Facility In-Charge to the DMO by the 7th day of each month. Summaries of LLINs issued at ANC and IVD clinics in all health facilities in each district will be reviewed for accuracy and completeness and then entered into the HMIS platform. The District HMIS Focal Person should enter this data into HMIS by the 14th day of each month.

This data entered into the HMIS platform will help in making programmatic decisions, including how to report on LLIN accountability and provide focused monitoring.

VI Accountability

Accountability at all levels is essential to the sustainability of an LLIN distribution program. Without proper accountability, program costs may be unnecessarily inflated. Fraud may result in loss of trust and financial support. To ensure accountability for the LLINs distributed through health facilities, officials at the health facility, district, regional and national levels should access and review monthly and quarterly reports that compare the expected and actual numbers of beneficiaries with the actual numbers of LLINs being ordered, delivered and distributed at all levels.

The following tasks should be conducted to ensure accountability for LLIN distribution:

Health Facility Level

- A physical count of LLINs delivered to health facilities should be conducted and verified, with proof of delivery signed by the Hospital Therapeutic Committee for district level facilities and by HFGC members at lower-level facilities.
- Health facility personnel are responsible for proper storage, safety, and issuing of LLINs to the target groups, and for regular and proper stocktaking.

Tools that are available for ensuring accountability of LLIN distribution at the health facility level, and the data they provide, are listed in Table 1.

Nyenzo zitakazotumika kuandaa ripoti ya uwajibikaji

Type of Tool	Type of Data
MSD sales invoice	- Quantities of LLINs issued by MSD
Ledger / stock card	• Quantities of LLINs received by facility • LLIN stock on hand • Number of LLINs issued to beneficiaries
R&R form	• Beginning LLIN balance • Quantities of LLINs received • Quantities of LLINs distributed • LLIN stock on hand • Quantities of LLINs requested
ANC register	• Number of LLINs issued to pregnant women
Under 5 register	• Number of LLINs issued to children receiving measles vaccine

District Level

- The Malaria Focal Person, working with the HMIS Focal Person and the District Pharmacist, will generate LLIN accountability data. This information will be used by the Malaria Focal Person to produce LLIN accountability reports, which will be reviewed by the DMO and approved by the Council Executive Director.
- The DMO will share the LLIN accountability report for the district with the District Executive Director (DED) and, together with the Council Executive Director, will discuss issues highlighted by the report with the District Monitoring Team. The District Monitoring Team will then use recommendations from the LLIN accountability report to inform targeted monitoring visits to health facilities as needed.
- The district LLIN accountability report will also be presented to the CHMT during their quarterly meetings. The CHMT together will decide on a plan of action for health facilities with detected variances.
- Data used to compile the LLIN accountability reports will be from existing systems such as HMIS and eLMIS.
- Both the DMO and the DED will be responsible for ensuring that all variances in LLIN accountability reports are followed up and resolved satisfactorily. The WEO, VEO and HFGC will support the District Monitoring Teams in follow-up visits to health facilities. For hospitals, the Hospital Management Team and Hospital Services Board will be responsible for ensuring that all variances are investigated and resolved.
- Updates on action items and actions taken based on LLIN accountability reports will be presented during CHMT meetings.
- The LLIN accountability reports from all districts will be shared with the RMO and RAS, along with recommendations and/or requests for additional support for implementation where needed.

Regional and Zonal Level

- The MoHCDGEC in collaboration with PORALG will conduct advocacy meetings to orient RASs, Council Directors, RHMTs and CHMTs on the health facility–based LLIN distribution program.
- The LLIN accountability reports from all districts will be submitted to the RMO and RAS.
- RHMTs and RASs will review district LLIN accountability reports and ensure that all variances at the health facility level in all districts are investigated and resolved satisfactorily and then discussed during RHMT meetings. The Regional Monitoring Team will support the District Monitoring Teams in effective monitoring of health facility–based LLIN distribution and will also help to follow up and resolve variances reported.

- Each quarter, each Regional Malaria Focal Person will compile all of their districts' LLIN accountability reports and submit them as a regional LLIN accountability report, along with actions taken, recommendations and/or requests for additional implementation support, to the MoHCDGEC and PORALG at the national level.
- The LMU will check the health facility requests for LLIN resupply to ensure that the requests are based on actual LLIN consumption/distribution data and to ensure that the correct numbers of LLINs are being supplied to bring each health facility's LLIN stocks up to their maximum stock level. Personnel from the LMU should also conduct visits to health facilities to encourage timely and accurate reporting and reordering.
- The zonal MSD will be responsible for safe storage and supply of LLINs to health facilities, and also for arranging for contracted transporters if a private transporter will be used. At the MSD warehouse, LLINs should be loaded onto vehicles in the presence of both the Warehouse Officer and the Vehicle Driver. The Vehicle Driver and the Warehouse Officer must both sign the proof of delivery notes to show mutual agreement on the quantity of LLINs loaded on the vehicle for delivery to health facilities. These signatures also transfer responsibility for the LLINs from the Warehouse Officer to the Vehicle Driver.

National Level

- The MoHCDGEC through NMCP will review the LLIN accountability reports from each region on a quarterly basis. A commodity management assessment/audit should also be conducted periodically (at least once a year) to review beneficiary, stock and delivery records to account for the numbers and flow of LLINs through the supply chain system.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VII Supervision, Monitoring and Evaluation

1. Supervision and Monitoring

Supervision is vital at the health facility level, especially in the early stages of implementing LLIN continuous distribution activities. Effective supervision helps to ensure good implementation and to identify issues and address them appropriately.

In the first 3 months of implementation, the trained Regional and District Monitoring Team, with support from the National Monitoring Team, should conduct supervision visits to all health facilities. The purpose of these initial supervision visits is to ensure the following:

- Health workers are conducting LLIN distribution at ANC and IVD clinics as expected, including educating beneficiaries on malaria prevention and LLIN net use, care and repair.
- Storekeepers are documenting LLIN stocks as required, and stocks on hand are as recorded (by physical count of LLINs).
- ANC and IVD clinic health workers are properly documenting the LLINs issued to beneficiaries in the ANC and IVD clinic registers as expected.
- Tallies of monthly LLINs issued are recorded correctly in the LLIN monthly HMIS summary forms.

Supervisors will provide on-the-job reorientation to health facility personnel who are not issuing, documenting and reporting processes as expected. New health workers will also be provided the necessary orientations.

Beyond the first 3 months of supervision visits, District and Regional Monitoring Teams and the LMU should incorporate the monitoring of LLIN continuous distribution activities into their routine quarterly MoHCDGEC monitoring visits to health facilities.

National level

Supervision and follow-up monitoring visits at the national level has to be conducted by the National Monitoring Team and LLIN Task Force members. The National Monitoring Team should conduct at least one monitoring visit to each region every year.

Regional level

Monitoring visits to districts will be integrated into the existing regional monitoring schedules. The Regional Monitoring Team and the Malaria Focal Person will lead these monitoring visits. Ad hoc monitoring visits may be conducted as needed. The Regional RCH Coordinator, Regional Pharmacist, Regional Malaria Focal Person and Regional HMIS Officer need to be involved in the regional monitoring visits.

At Council/District level

Monitoring of LLIN distribution in health facilities will be integrated into the district's existing monitoring schedules. Ad hoc monitoring visits to health facilities may be conducted when needed. The District RCH Coordinator, District Pharmacist, District Malaria Focal Person and Council/District HMIS Officer should be part of the District Monitoring Team and need to be involved in these monitoring visits.

All monitoring teams should check for the following during monitoring visits:

- LLINs are available, with stocks that are not below minimum threshold.
- LLIN stock reports are accurate, to ensure that the LLIN resupply/restocking system is working properly.
- Health facility stores and ANC and IVD clinics are secure and appropriate for storing LLINs.
- ANC and IVD registers and summary records of LLINs distributed are properly documented and reported.
- Health workers' are familiar with malaria messaging, SBCC materials are well placed/well displayed and job aids are available.

Monitoring teams should also review the reports from previous monitoring and supervision visits and discuss findings, actions taken and further action needed for effective LLIN distribution.

A supplementary **Health Facility Monitoring Checklist (Appendix XII)** for assessing LLIN storage, documentation and reporting of LLINs issued at ANC and IVD clinics should be used in addition to other tools during routine health facility monitoring visits. An analysis of issues observed during monitoring and supervision visits and corrective measures taken or recommended should be included in the reports and discussed at district, regional and national coordination meetings.

Reports on these indicators should be complemented by a brief explanation of trends observed, challenges faced and lessons learned. Targets, indicator definitions and a template for summarizing trends should be developed as part of the LLIN accountability reports.

2. Evaluations

To evaluate the impact of health facility–based LLIN distribution, the following indicators should be considered:

- Household LLIN ownership
- Household LLIN access and population access
- Net use the previous night before the survey
- Contribution of health facility–based LLIN distribution to overall LLIN ownership and access levels, relative to other sources/channels of LLINs
- Cost-effectiveness of health facility–based LLIN distribution

Evaluations can take the form of stand-alone studies (as in the case of a cost-effectiveness analysis) or can be integrated into ongoing studies such as the Demographic Health Survey or the Malaria Indicator Survey.

Process evaluations can also be used to complement monitoring and impact evaluation data to get a qualitative understanding of how well guidelines have been followed for implementation, what challenges have emerged and what promising practices should be adopted.

Table 2 lists the indicators that should be tracked at district, regional and national levels using the HMIS, eLMIS, ILSGateway and accountability reports. Where possible, these indicators should be added to and aligned with the national malaria monitoring and evaluation plan.

Table 2: Indicators to Be Tracked for Monitoring Health Facility–Based LLIN Distribution

Indicator	Data Source	Frequency	Target
% of pregnant women receiving an LLIN during their first ANC visit	HMIS	Monthly	100%
% of children receiving their measles vaccine who also receive an LLIN	HMIS	Monthly	100%
Number of LLINs distributed through ANC and IVD clinics	HMIS	Monthly	TBD (projected number)
% of health facilities not reporting stockout during the reporting period that were visited by the VectorWorks supervision team for verification	ILSGateway or eLMIS	Quarterly	90% (of facilities that did not report stockout)
% of facilities reporting variances (red flags) that were visited by the VectorWorks supervision team for verification	Accountability report	Quarterly	95%
% of variances (red flags) investigated/ followed up on	Accountability report	Quarterly	100%

VIII Social and Behavior Change Communication

The rollout of health facility–based LLIN distribution should be accompanied by mass media and interpersonal communication to boost service utilization and LLIN use. Mass media and interpersonal communication activities should be integrated into highly recognized ongoing mass communication platforms for maternal and child health. In addition, mothers and caregivers should receive appropriate messages on LLIN use, care and repair during health education talks at ANC and IVD clinics, while LLIN use and health facility–based LLIN distribution should be promoted during all community or social mobilization activities.

Community members should be informed about the following:

- The importance of accessing ANC and IVD services
- The right of pregnant women and children to get a free LLIN at a health facility
- The ways in which pregnant women and children can access and obtain LLINs
- The importance/benefits of nightly use of LLINs by families, and of LLIN care and repair
- Recommended ways of washing and drying LLINs

The NMCP's SBCC Working Group, implementing partners and creative teams should organize a design workshop to develop a mass media and community mobilization campaign that will include SBCC materials, community mobilization and media activities. The design workshop will aim to develop content and come up with creative ideas for all SBCC material and job aids for health providers, HFGC members and mass media producers/journalists/radio program hosts. Materials and messages developed should be developed in consultation with the MoHCDGEC and the NMCP and harmonized with the national malaria communication strategy.

The mass media campaign should be broadcast through regional or community radio stations. Community mobilization activities will be conducted by community change agents at the ward level with support from volunteers. Community change agents, Ward Health Officers, health providers and journalists/radio program hosts will undergo orientation to SBCC message and job aids to promote health facility–based LLIN distribution and LLIN use, care and repair. Community change agents and Ward Health Officers will be trained together in their districts. Media producers/journalists/radio program hosts from various media houses will be oriented at the regional level.

Broadcast and community mobilization activities should start immediately after SBCC orientation. All SBCC orientations/trainings should therefore take place at least 3 months before the issuing of LLINs at health facilities begins.

IX Annual Budget/Costing

The parameters for costing of health facility–based LLIN distribution at the national level should include LLIN procurement, storage and transportation, trainings, SBCC, coordination, monitoring and supportive supervision.

X Roles and Responsibilities

Table 3:
Roles and Responsibilities of Personnel and Organizations at All Levels

Person/Organization	Responsibilities
National Level	
MoHCDGEC and NMCP	• Develop implementation guidelines, training materials, and reporting and supervision tools and submit them for review by the LLIN Task Force distribution subcommittee. • Provide technical coordination for health facility–based LLIN distribution activities at the national level. • Train national trainers and monitor lower-level trainings. • Ensure consistent use of implementation guidelines and reporting and supervision tools for health facility–based LLIN distribution. • Provide LLIN quantification, forecasting and requests for continuous stock resupply. • Coordinate LLIN distribution–related research activities. • Ensure the alignment of health facility–based LLIN distribution with the National Malaria Strategic Plan and vector control policy. • Include health facility–based LLIN distribution updates and challenges in the agenda for LLIN Task Force meetings and NATNETS Steering Committee meetings as appropriate, and organize ad hoc meetings to discuss related issues when necessary. • Communicate the health facility–based LLIN distribution strategy to all RASs through PORALG. • Collect and review LLIN data and accountability reports from the regional level. • In collaboration with PORALG, conduct monitoring visits to regions, districts and health facilities.
RCH	• Support training of national trainers at the national level. • Coordinate health facility–based LLIN distribution activities at the regional, district and health facility levels. • Monitor and supervise health facility–based LLIN distribution in health facilities. • Maintain involvement in SBCC strategic activities.

Person/Organization	Responsibilities
Pharmaceutical Services Section, MSD and implementing partners	• Coordinate and compile data to forecast and quantify the nation's LLIN needs and to advise on troubleshooting and procurement planning. • Ensure that appropriate and secure storage spaces for LLINs are available at zonal warehouses and health facilities. • Ensure timely initial supply and restocking of LLINs to zonal warehouses and health facilities. • Review and approve requisitions/orders for restocking of LLINs to zonal warehouses. • Coordinate the monitoring and supervision of the LLIN logistics and supply chain system.
PORALG (Health, Social Welfare and Nutrition Directorate and Sector Coordination Directorate)	• Communicate the health facility–based LLIN distribution strategy to all RASs and DEDs. • Coordinate the implementation of LLIN distribution activities. • Collect and review LLIN accountability reports from RASs and share with other ministries and implementing partners. • In collaboration with the MoHCDGEC, conduct monitoring visits to regions, districts and health facilities. • Participate in national level coordination meetings, such as LLIN Task Force meetings and NATNETS Steering Committee meetings.
Implementing Partners	• With the NMCP, conduct informational and advocacy meetings to inform the MSD, RCH, PORALG and RMOs of the new program. • Support development of implementation guidelines, training materials, and reporting and supervision tools and submit them for review by the LLIN Task Force distribution subcommittee. • Support the subcommittee in the formation of agenda items and terms of reference for their meetings. • Support the inclusion of quarterly accountability reports and supervision reports in meeting agendas. • Participate in subcommittee meetings and provide updates on the progress of LLIN activities. • Work with the MoHCDGEC (NMCP Vector Control Focal Person) and PORALG to review quantification data. • Support the training of national trainers. • Asist the NMCP Vector Control Focal Person in compiling the quarterly accountability reports. • Cooperate with researchers in the design of any evaluations (if and when any evaluations are planned). • Develop a transition plan for the gradual takeover of storage and transport responsibilities by the MSD.

Person/Organization	Responsibilities
SBCC implementing partners	• Develop SBCC materials. • Contract with radio stations to air mass media materials. • Incorporate any interpersonal communication materials into existing community mobilization activities. • Share media and SBCC activity monitoring data with the national LLIN Task Force distribution subcommittee. • Report any issues in SBCC implementation to the CHMTs, RHMTs and the national subcommittee.
Development partners / donors	• Procure LLINs and ensure that they arrive in Tanzania. • Provide resources and technical assistance for implementation of LLIN distribution. • Conduct LLIN stock verification and audits.
Zonal Level	
MSD and LMU	• MSD zonal warehouses receive and store LLINs. • LMU receives, reviews and approves R&R forms for LLIN supply. • LMU communicates with districts to ensure that LLIN ordering forms are completed correctly and in a timely manner. • MSD processes approved orders and restocks health facilities with LLINs based on the scheduled delivery plan. • MSD shares LLIN delivery and stock data with NMCP to ensure a minimum LLIN stock level of 6 months is always available at the zonal level for supply to health facilities. • LMU conducts supervision visits to health facilities to strengthen LLIN stock management and reporting. • LMU monitors reports from the ILSGateway for potential stockouts of LLINs at the health facility level.
Implementing partners	• Assess the capacity of zonal warehouses and transporters. • Conduct competitive bidding for storage and transport. • Contract and pay for the storage of LLINs and SBCC materials at the zonal level. • Obtain copies of LLIN orders from the zonal LMUs. • Develop transport plans. • Contract and pay for the transport of LLINs and SBCC materials (both initial stocks and resupply) from zonal warehouses to health facilities. • Collect Good Received Notes from transporters.

Person/Organization	Responsibilities
Regional Level	
RAS	• Communicate the health facility–based LLIN distribution strategy to all councils. • Support councils in ensuring accountability for LLINs from the health facility–based LLIN distribution program. • Integrate health facility–based LLIN distribution into agendas for regional coordination meetings. • Supervise implementation of health facility–based LLIN distribution activities within a region. • Collect and review councils' LLIN accountability reports. • Compile regional LLIN accountability reports and obtain input for action. • Submit regional LLIN accountability reports to NMCP. • Take necessary action on the regional LLIN accountability report provided by the RMO. • Share regional LLIN accountability reports with PORALG's Director for Health, Social Welfare and Nutrition. • Participate in training and supervision activities for health facility–based LLIN distribution.
Implementing partners	• Participate in informational and advocacy meetings to inform the RASs and RMOs of the new program. • Support the RHMTs in forming agenda items and terms of reference for their meetings; advocate to include quarterly accountability reports and supervision reports in meeting agendas. • Supervise and pay for the training of regional and district trainers. • Supervise and pay for the first quarter supervision visit by regional and district teams. • Collect training and supervision reports from the regional and district teams. • Provide on-call technical assistance to the Regional Pharmacist on compiling the quarterly accountability reports. • Work with RHMTs to include review of the supervision reports and quarterly accountability reports in the standing agenda for their meetings. • Participate in RHMT meetings and provide updates on the progress of implementing partner activities.
Supply chain implementing partner	• Transport LLINs from the port to the MSD.

Person/Organization	Responsibilities
District Level	
Council Director / DED	• Communicate the health facility–based LLIN distribution strategy to the health facilities and political leaders/officers (WEOs, VEOs, counselors, etc.). • Coordinate all health facility–based LLIN distribution activities within the district. • Integrate health facility–based LLIN distribution into agendas for council coordination meetings. • Collect and review council LLIN accountability reports from health facilities and take necessary action. • Provide input to the council LLIN accountability reports. • Submit the council LLIN accountability reports to Regional Administrative Secretary (RAS). • Ensure accountability for LLINs from the health facility–based LLIN distribution program. • Facilitate the training of health facility staff, with the assistance and engagement of the district technical committee team. • Review and approve requisitions/orders submitted by health facilities for restocking of LLINs. • Integrate supervision of ANC and IVD clinics' LLIN distribution into routine supervision visits.
Implementing partners	• Conduct informational and advocacy meetings to inform the DMOs and the DEDs of the new program. • Support the District Health Management Team (DHMT) and CHMT in forming agenda items and terms of reference for their meetings. • Advocate to include quarterly accountability reports and supervision reports in meeting agendas. • Supervise and pay for the training of regional and district trainers. • Supervise and pay for the first quarter supervision visit by regional and district teams. • Collect training and supervision reports from the regional and district teams. • Provide on-call technical assistance to the District Pharmacist on compiling the quarterly accountability reports. • Work with DHMTs to include review of the supervision reports and quarterly accountability reports in the standing agenda for their meetings. • Participate in DHMT meetings and provide updates on the progress of implementing partner activities. • Incorporate SBCC messages and materials into existing community mobilization activities.

Person/Organization	Responsibilities
Health Facility / Community Level	
Health facility staff	• Receive LLINs and track their consumption using stock cards. • Store LLINs securely and protect them from damage. • Report data on LLINs received, stock on hand, losses and adjustments every 3 months using the R&R forms. • Reorder nets from the MSD in a timely fashion by submitting R&R forms to the district level. • Issue LLINs to pregnant women during their first ANC visit for each pregnancy. • Issue LLINs to children receiving the measles vaccine. • Issue LLINs to infants eligible for the measles vaccine during outreach services. • Properly document LLINs issued to beneficiaries. • Sensitize patients about LLIN use, care and repair. • Coordinate with the HFGC and community change agents to promote the health facility–based LLIN distribution service. • Report ANC and IVD service data as well as LLIN issuing data to the DMO every month using the monthly antenatal and immunization HMIS forms. • Report LLIN stock on hand every month using the ILSGateway forms.
HFGC, including the VEO	• Receive and countercheck LLINs supplied to health facilities with health facility staff. • Educate and motivate community members on malaria prevention, including use of LLINs. • Assist with follow-up visits to health facilities on variances based on LLIN accountability reports.
WEOs and VEOs	• Assist with follow-up visits to health facilities on variances based on LLIN accountability reports. • Assist with resolving other issues related to health facility–based LLIN distribution in the community.

Appendices

XI Appendices

Existing Forms

Appendix I:	Report & Requisition Form
Appendix II:	Health Facility Ledger/Stock Card
Appendix III:	Proof of Delivery/MSD Sales Invoice
Appendix IV:	Claims Invoice
Appendix V:	ANC Register
Appendix VI:	Pregnant Woman Antenatal Card
Appendix VII:	Under 5 Register
Appendix VIII:	Child Immunization Card
Appendix IX:	HMIS Summary Forms for ANC
Appendix X:	HMIS Summary Forms for Under 5
Appendix XI:	Monthly Accountability Report
Appendix XII:	Quarterly Accountability Report
Appendix XIII:	Health Facility Monitoring Checklist

Wizara ya Afya na Ustawi wa Jamii

FOMU 2A:TAARIFA NA MAOMBI YA DAWA NA VIFAA MUHIMU KWA ZAHANATI NA VITUO VYA AFYA KUTOKA BOHARI YA DAWA

Namba ya Utambulisho ya kituo: _____

Jina la Kituo: _____

Jina la Halmashauri: _____

Umiliki/(GOV/NGO/FBO/Other/Nyingine): _____

Idadi ya watu katika kituo: _____

Kundi:(A/B/C)_____

Tarehe ya Kuwasilisha Fomu: _____

Kipindi cha Taarifa:

Kuanzia Mwezi-Mwaka: _____

Kuishia Mwezi-Mwaka:_____

DAWA NA VIFAA TIBA				TAARIFA						MAOMBI		KIASI & GHARAMA						
Namba Mpya ya MSD	Maelezo ya bidhaa	Nguvu	Kipimo cha ugavi	Kiasi cha kuanzia	Kiasi kilichopokelewa	Upotevu au Marekebisho	Siku ambazo dawa haikuwepo kituoni	Salio la mwisho	Makadirio ya matumizi	Kaisi cha juu kinachohitajika	Kiasi kinachoagizwa	Kiasi cha juu baada ya marekebisho	Kiasi cha marekebisho kinachohitajika	Kiasi kinachoombwa	Bei	Ghara ma	Kiasi kilichoidhinishwa	Ghara ma iliyoidhinishwa
				[A+B+C-D] (A)	(B)	(C)	(X)	(D)	[E*2] (E)	[Y-D] (Y)	(F)	[Y*90/(90-X)] (Z)	[Z-D] (G)	(H)	(I)	[HxI] (J)	(K)	[KxI] (L)
Analgesics																		
10010001MD	Acetylsalicylic acid (asprin)	300 mg	1000 tablets															
10010022MD	Paracetamol Tabs	500 mg	100 tablets															
10010044MD	Paracetamol	500 mg	1000 tablets															
10040012MD	Paracetamol Syrup	120mg/ 5mls, 100mls	24 bottles															
Anaesthetics																		
10060070MD	Lignocain 50ml Inj	2.00%	10 vials															
Anti-allergies and Medicines used anaphylaxis and Shock																		
10010014MD	Chlorpheniramine	4 mg	1000 tablets															
10060008MD	Adrenaline 1ml Inj	1 mg/ml	10 vials															
Antibiotics																		
10010007MD	Amoxicillin Caps	250 mg	1000 tablets															
10010020MD	Co-trimoxazole tabs	400mg/ 80mg	1000 tablets															
10010024MD	Doxycycline tabs	100 mg	1000 tablets															
10010026MD	Erythromycin tabs	250 mg	1000 tablets															
10010040MD	Metronidazole tabs	200 mg	1000 tablets															
10010047MD	Phenoxymethyl Penicillin tabs	250 mg	1000 tablets															
10010059MD	Ciprofloxacin tabs	500 mg	100 tablets															
10040003MD	Erythromycin Granules	125mg/ 5ml	100ml bottle															

Zahanati au Kituo cha Afya kinawasilisha kwa DMO nakala A na B. Baki na Nakala C. Wilaya inatuma MSD nakala A. Baki na nakala B (1)

Namba Mpya ya MSD	Maelezo ya bidhaa	Nguvu	Kipimo cha ugavi	Kiasi cha kuanzia	Kiasi kilichop okelewa	Upotevu au Marekebisho	Siku ambazo dawa haikuwe po kituoni	Salio la mwisho	Makadi rio ya matumi zi	Kaisi cha juu kinachoh itajika	Kiasi kinachoa gizwa	Kiasi cha juu baada ya marekeb isho	Kiasi cha marekebis ho kinachohit ajika	Kiasi kinach oomb wa	Bei	Ghara ma	Kiasi kilich oidhin ishwa	Ghara ma iliyoidh inishwa
				(A)	(B)	(C)	(X)	(D)	[A+B+C-D] (E)	[E*2] (Y)	[Y-D] (F)	[Y*90(90-X)] (Z)	[Z-D] (G)	(H)	(I)	[HxI] (J)	(K)	[KxI] (L)
10040010MD	Amoxicillin Granules	125mg/ 5ml	24 Bottles															
10040015MD	co-trimoxazole Suspension	200/40/ 5ml	24 bottles															
10060013MD	Benzzathine Penicillin Fortifield Pdr F Inj	2.4 mu	50 vials															
10060014MD	Benzyl Penicillin Pdr F Inj	5 mu	50 vials															
10060016MD	Ceftriaxone Powder Inj	250 mg	20 vials															
10060017MD	Chloramphenicol Pdr F Inj	1 G	20 vials															
10060046MD	Procaine Penicillin Fortified Pdr F Inj	4 mu	20 vials															
10010013MD	Chloramphenicol Caps	250 mg	1000 Capsules															
10010019MD	Cloxacillin Caps	250 mg	1000 Capsules															
10060073MD	1G Ceftriaxone Pdr F Inj	1g	1 vials															
10060076AB	Spectinomycin Inj	2gm	1 vials															
Antihelmithics																		
10010003MD	Albendazole tab	200mg	100 tablets															
10010038MD	Mebendazole	100mg	1000 tablets															
Antifungals																		
10050014MD	Clotrimazole Cream / Ointment	1%, 20mg	24 tubes															
10050004MD	Benzoic Acid Compound	6%+3%	40 grams															
Antimalarials																		
10010169BE	Artemether / Lumefantrine (Njano -1x6)	20/ 120mg	T/180															
10010170BE	Artemether / Lumefantrine (Blue -2x6)	20/ 120mg	T/360															
10010171BE	Artemether / Lumefantrine (Kijani -4x6)	20/ 120mg	T/720															
10010002BE	Artemether / Lumefantrine (Kahawia -3x6)	20/ 120mg	T/540															
10060048MD	Quinine 2ml Inj	300mg/ ml	10 vials															
10010120BE	Sulphadoxine + Pyrimethanine	500mg/ 25mg	100 tablets															
10010202MD	Quinine Sulphate	300 mg	500 tablets															
10060237MD	Artesunate Inj	60 mg	50 vials															

Zahanati au Kituo cha Afya kinawasilisha kwa DMO nakala A na B. Baki na Nakala C. Wilaya inatuma MSD nakala A. Baki na nakala B (2)

JAMHURI YA MUUNGANO WA TANZANIA

WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA

MTUHA TOLEO LA 2.0

KITABU CHA 4: LEJA

Jina la Kituo _____ Stoo _____

Wilaya _____ Tarhe ya kuanza _____ Tarehe ya kumaliza _____

KUMBUKUMBU YA DAWA NA KIFAA	**Namba ya Ukurasa ……….**

Namba ya Dawa/Kifaa	Jina la Dawa/Kifaa	Hali maalum ya utunzaji inayohitajika	
Kiasi kinachokubalika kuagiza		Maelekezo maalum ya uagizaji	
Kipimo kinachotumika	Kiwango cha juu kabisa	Kiwango cha chini kabisa	Mahali pa kutunzia

Tarehe	Kumbukumbu za kuagizia/kutoa	Kiasi kilichopokelewa	Kiasi kilichotolewa	Marekebisho (Upotevu, kurudishwa)	Kiasi kilichopo	Maelezo

msd
medical stores department

TIN NO: 101-060-195 **ISO 9001:2008 CERTIFIED**

Sales Invoice

Invoice No: …… **Zone: ……**

Sold to:

……
……
……
……

Shipped to:

……
……
……
……

Sales Order No:…… Sales Category: ……

Invoice Date …… Payment Terms: ……

Customer Ref…….. Sales Person: ……..

Shipped Via …….. Delivery terms: ……..

Item Code	Description	UoM	Qty	Batch No	Batch Qty	Expiry Date	Unit Price	Total
Total								

Order Miscellaneous Charges:

Description	Amount (TZS)
Total	

msd

medical stores department

Invoice Line Total	
Invoice Line Discount	
Invoice Misc. Charges	
Invoice Total	

Invoice Total in Words:

……

Missed Items

Item Code	Description	UoM	Qty	Reason

……	……	……	……..
Prepared By:	Authorized Signature	Invoice Acceptance	Delivery acceptance
(MSD)	(MSD)	(Customer)	(Customer)
Date……..	Date……..	Date……..	Date……..

FORM 7: VERIFICATION AND CLAIMS FORM

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

Name of Health Facility …… Cycle ……... Group ……

MSD Invoice No. …….. Vehicle Number…….

Driver's Name …… Signature……Date……

Physical Control of Received Items

Item Ordered but not received accordingly			
Order Form	Item Description	Quantity Ordered	Quantity Received

Items with close expiry date (3 months to expire)		
Item Description	Quantity	Expiry Date

Discrepancy

Breakages					
Invoice No.	Code	**Item Description**	Unit	Quantity	Remarks

Invoiced but not received						
Invoice No.	Code	Item Description	Unit	Invoiced Qty	Received Qty	Remarks

Over Issued						
Invoice No.	Code	Item Description	Unit	Invoiced Qty	Received Qty	Remarks

Name of HF in-charge ……..……..Signature……..Date ……...

Name of Witness 1…. ……..Signature……..Date ……...

Name of Witness 2 ……..Signature……..Date ……...

Name of Witness 3…..……..Signature……..Date ……...

DMO Office:

Seen and forwarded to MSD/ZMS

Name……..Signature……..Date ……..

"SIRI"

JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA

MTUHA TOLEO LA TATU: MWAKA 2014

KITABU CHA 6: REJESTA YA WAJAWAZITO

Jina la Kituo..... Wilaya.....

Tarehe ya Kuanza..... Tarehe ya Kumaliza.....

MWONGOZO WA KUJAZA REJESTA YA WAJAWAZITO

Safu ya (1): Na. Andika namba ya kuandikishwa anza na 001 kila mwezi

Safu ya (2): Tarehe: Tarehe ya hudhurio la kwanza. Jaza tarehe kwa tarakimu na mwezi katika herufi tatu za mwanzoni kwa kifupi. Kwa vile mwaka unaandikwa katika jalada la kitabu hiki usiandike mwaka.

Safu ya (3): Namba ya usajili: Utatumia namba zinazofuatana kwa kuanzia 001 kila tarehe 1 Januari. Safu ndogo ya kwanza utajaza mwaka na safu ya pili utajaza namba ya mteja. Kama mteja atapoteza kadi yake, mpe kadi nyingine ila usimpe namba mpya ya utambulisho. Tafuta namba yake katika rejesta *(muulize alisajiliwa lini)* na tumia namba ile ile ya mwanzo. Idadi ya wateja wapya inafuatiliwa kila mwezi, robo mwaka na kutolewa ripoti kila mwisho wa mwaka.

Safu ya (4): Jina kamili la mteja: Andika majina matatu halisi ya mteja kwa usafi. Andika kwa herufi kubwa

Safu ya (5) : Umri: Andika umri kamili wa mama (miaka iliyokamilika)

Safu ya (6): Mahali mteja anapoishi: Andika jina la Kijiji/Kitongoji/Balozi, mtaa/barabara, namba ya nyumba/,

Safu ya (7): Mume/Mwenza: Andika majina matatu kamili ya mume au mwenza

Safu ya 8): Jina la mwenyekiti serikali ya mtaa: Andika jina la mwenyekiti serikai ya mta/kitongoji

Safu ya (9: tarehe ya chanjo ya TT:

i. **"N" ana kadi, andika N kama ana kadi na H kama**

ii. **Andika tarehe ya TT1**

iii. **Andika tarehe ya TT2 na zaidi**

Safu ya (10) : Umri wa mimba kwa wiki: Kadiria umri wa mimba kwa kutumia tarehe ya mwisho mama alipopata hedhi yake (LNMP). Umri ukadiriwe kwa wiki.

Safu ya (11): Taarifa ya mimba zilizopita: Andika taarifa muhimu za mama kuhusu mimba za hapo awali; mimba ya ngapi, amejifungua mara ngapi, watoto hai, mimba zilizoharibika, kujifungua mtoto mfu/kifo cha mtoto mchanga ndani ya wiki moja na umri wa mtoto wa mwisho ili kuweza kupata dondoo zitakazo kuwezesha kumshauri juu ya ujauzito alionao, jaza kwa tarakimu, mfano: *mimba zilizoharibika,* Jaza 1 (kama ni mimba moja).

Safu ya (12) :Vipimo/Taarifa Muhimu kuhusu vidokezo vya hatari: Vimeorodheshwa katika safu hii. Kiwango cha Damu, Shinikizo la damu, " UREFU' – yaani urefu wa mama mjamzito katika sentimeta, Jaza kila kimoja kinapohusika. Kujifungua kwa Oparesheni andika N (Ndiyo) au H (Hapana), Umri chini ya miaka 20 na Umri zaidi ya miaka 35 weka alama ya tiki (√) . Sukari kwenye mkojo andika "H" kama hakuna sukari kwenye mkojo au "N" kama kuna sukari kwenye mkojo.

Safu ya (13): Kipimo cha kaswende: Upimaji wa kaswende kwa mama mjamzito katika vituo vya kutolea huduma za afya unafanyika kote nchini. Upimaji ufanyike hudhurio la kwanza umuonapo mama mjamzito. Kila mara unapofanya kipimo hiki matokeo yake lazima yaandikwe kwenye rejesta. Iwapo matokeo ni "Negative" andika N Iwapo matokeo ni "Positive" andika P. Ikiwa hajapimwa acha wazi. Mteja ambaye ni P ashauriwe kwenda kumleta mume/mwenza/wenza kwa ajili ya kupimwa na kutibiwa. Mke akitibiwa weka "N" (ndiyo) chini ya KE na kama mume/mwenza ametibiwa weka "N" (ndiyo) chini ya ME, kama hajatibiwa weka "H" (hapana). Vipimo vya magonjwa yatokanayo na ngono isiyo salama (Yasiyo Kaswende) iwapo matokeo ni "Negative" andika "N", iwapo matokeo ni "Positive" andika "P". Ikiwa hajapimwa acha wazi. Mteja ambaye ni "P" ashauriwe kwenda kumleta/kuwaleta mume/mwenza/wenza kwa ajili ya kupimwa na kutibiwa. Mke akitibiwa weka "N" (ndiyo) chini ya KE na kama mume/mwenza ametibiwa weka "N" (ndiyo) chini ya ME, kama hajatibiwa weka "H" (hapana).

Safu ya (14): **Mahudhurio ya Marudio**: Kila hudhurio la marudio, zingatia yafuatayo:- Anaemia, andika "A" kuharibika mimba mfululizo zaidi ya mara mbili, andika "KM", High blood pressure, andika "H", proteinuria, andika "P", Kutokuongezeka uzito, andika "U", Kutoka damu ukeni, andika "D", Mlalo mbaya wa mtoto, andika "M", Mimba zaidi ya nne, andika "M4", **Kuzaa kwa oparesheni, andika „cs", Kuzaa kwa vaccum, andika „VE", Kifua kikuu, andika „TB". Weka alama zilozo**onyeshwa chini ya hudhurio linalohusika. Weka alama ya tiki (√) iwapo mama hakuwa na tatizo. Endapo mteja hakuhudhuria usijaze chochote. Andika „V" kama hana matatizo.

Safu ya (15): Huduma za PMTCT:

Muulize mama kama ana fomu/kadi ya majibu ya kipimo cha VVU kutoka PMTCT, CTC au TB/HIV; halafu angalia majibu kama ni *Positive (1)* au *Negative (2).*

Tayari ana maambukizi ya VVU: Weka alama ya tiki kama mama mjamzito anafahamu kuwa ana maambukizi ya VVU kabla ya kuanza kliniki ya ujauzito na uthibitisho kama hana maambukizi acha wazi.

Tarehe ya unasihi: Kama hali yake ya VVU haijulikani apewe ushauri nasaha kisha achukuliwe vipimo vya VVU. Kwenye sehemu **Ke;** Andika **tarehe ya unasihi** kama amepata ushauri nasaha au acha wazi kama hakupata; jaza hivyo hivyo kwa sehemu ya **Me** kama mteja amekuja na mwenzi wake

Amepima VVU: Wajawazito walipiomwa VVU na wenza wao (Couple) kwa pamoja katika kliniki ya wajawazito: Kwenye sehemu **Ke;** Andika **N** kama amepima, acha wazi kama hakupima; jaza hivyo hivyo kwa sehemu ya Mwenza Me kama amepima. Andika **P** kama mjamzito amepima pamoja na mwenzi wake

Tarehe ya kipimo: Andika tarehe ambapo kipimo cha VVU kilifanyika kwa wajawazito/wenza

Matokeo ya kipimo cha VVU: Baada ya kupima, Kwenye sehemu **Ke;** Andika **P** kama ni Positive au **N** kama ni Negative. Jaza hivyo hivyo kwa sehemu ya **Me** kama amempima na mwenzi wake

Unasihi baada ya kupima: Kama mama amepata ushauri nasaha baada ya kupima VVU .Kwenye sehemu **Ke;** andika **N**, kama mama hakupata ushauri nasaha andika H. Jaza hivyo hivyo kwa sehemu ya **Me** kama mwenzi wake amepata ushauri nasaha baada ya kupima.

Matokeo ya kipimo cha pili cha VVU kwa mama. Baada ya kupimo cha pili cha VVU, Andika **P** kama ni Positive au **N** kama ni Negative.

Amepata ushauri juu ya ulishaji wa mtoto: Andika **N** kama mama amepata ushauri juu ya ulishaji wa mtoto au acha wazi kama mama hakupata ushauri mpaka hapo atakaposhauriwa ndipo utajaza.

Safu ya (16): Malaria. Mjamzito anatakiwa kupima malaria kwa kutumia mRDT au "Blood slide" anapokuja kwa mara ya kwanza.

Matokeo ya kipimo cha Malaria: andika "P" kama mama ana Malaria au **"N"** kama hana Malaria. Mjamzito mwenye vimelea vya malaria "P" apewe matibabu ya malaria. Endapo hana vimelea vya malaria "N" apewe SP ya IPT kulingana na mwongozo.

Hati Punguzo-ITN/LLN: Iwapo amepewa hati punguzo kwa ajili ya kupatiwa chandarua chenye dawa ya muda mrefu **(LLN)** au muda mfupi **(ITN)** andika **"N".** Iwapo hajapewa acha wazi hadi hapo atakapopatiwa chandarua.

Tarehe aliyopewa IPT1 ya Malaria: Dawa aina ya SP inatolewa kuanzia wiki ya 14 ya ujauzito. Iwapo mama mjamzito amepewa dawa hii andika tarehe aliyopewa. ***KUMBUKA: Mama atapewa kila hudhurio, kuanzia wiki ya 14 na kila hudhurio linalofuata, ili mradi inapishana wiki nne.***

Tarehe aliyopewa IPT2 ya Malaria: Andika tarehe aliyopewa dose ya pili ya SP.

Tarehe aliyopewa IPT3 ya Malaria: Andika tarehe aliyopewa dose ya tatu ya SP.

Tarehe aliyopewa IPT4 ya Malaria: Andika tarehe aliyopewa dose ya nne ya SP.

Safu ya (17): Iron (I)/ Folic (FA)/IFA: Iwapo mama mjamzito ameanzishiwa iron andika idadi ya vidonge na herufi "I", Iwapo mama mjamzito ameanzishiwa Folic Acid andika idadi ya vidonge na herufi "F" na iwapo mama mjamzito ameanzishiwa zote (Iron (I)/ Folic Acid (IFA)) andika idadi ya vidonge na herufi "IFA". ***KUMBUKA: Mama anatakiwa apewe vidonge vya kutosha kumeza kila siku wakati wa ujauzito hadi siku 90 baada ya kujifungua.***

Safu ya (18): Dawa ya minyoo (Albendazole/Mebendazole): Iwapo mama mjamzito amepewa dawa ya minyoo (Albendazole/ Mebendazole /) andika "N", Iwapo mama mjamzito hajapewa dawa ya minyoo (Albendazole/Mebendazole) usiandike chochote hadi hapo atakapopewa dawa za minyoo.

Safu ya (19): Rufaa: Kama mjamzito amepewa rufaa kutokana na tatizo lolote andika jina la kituo/sehemu alikopelekwa, tarehe na sababu ya rufaa. Au kama mjamzito amepewa rufaa kutokana na tatizo lolote, andika jina la kituo/sehemu alikotokea, tarehe na sababu ya rufaa: Mfano Amezidiwa, ameomba mwenyewe, CTC, PMTCT n.k.

Safu ya (20): Maoni: Andika maoni au mengineyo kama yalivyojitokeza

1	2	3		4	5	6	7	8	9			10	11						12						
Na.	Tarehe	Namba ya Usajili		Jina kamili ya mteja	Umri	Jina la Kijiji/Kitongoji/ Balozi,mtaa/barabara/ Na. ya nyumba	Mume/Mwenza (Jina)	Jina la M/kiti Serikali ya \Mtaa/ Kitongoji	Tarehe ya Chanjo ya TT			Umri wa Mimba Kwa Wiki	Taarifa ya Mimba Zilizopita						Vipimo/Taarifa Muhimu						
		Mwaka	Na.						"N"ana kadi, "H" hana kadi	Andika tarehe ya TT1	Andika tarehe ya TT2+		Mimba ya ngapi	Umezaa mara ngapi?	watoto hai	Mimba zilizo haribika	FSB/MSB/kifo cha mtoto katika wiki moja "N" ndiyo	Umri wa Mtoto wa Mwisho	Kiwango cha damu (HB) mfano 11.0	Shinikizo la damu (BP): "N" Ndiyo "H" Hapana	Urefu (cm)	Sukari kwenye mkojo: "N"Ndiyo, "H" Hapana	Kujifungua kwa CS "N" Ndiyo, "H" Hapana	Umri chini ya Miaka 20 (√)	Umri zaidi ya miaka 35 (√)

13								14								15														16						17				18	19				20
Kipimo cha Kaswende				Vipimo vya Magonjwaya ngono				Mahudhurio ya Marudio								Huduma ya PMTCT														Malaria						Idadi ya vidonge vya "I" Iron / "FA" Folic Acid /				Amepata Albendazole/Mebendazole: "N" Ndiyo	Rufaa				Maoni
Matokeo: "P" Positive, "N" Negative		Ametibiwa: "N"Ndiyo, "H" Hapana		Matokeo "P" Positive, "N" Negative		Ametibiwa "N" Ndiyo, "H" Hapana		Andika: √" Kama hana matatizo, "KM" kuharibika mimba mfululizo x2+, "A" anaemia, "P" protenuria, "H" High BP, "U" kutoongezeka uzito, "D" Damu ukeni, "M" mlao mbaya wa mtoto, "M4" mimba 4+, "C/S" kuzaa kwa operesheni, "VE" Vacuum extraction, "TB"								Tayari ana maambukizi ya VVU		Amepata unasihi Tarehe		Amepima VVU "N" Ndiyo, "P" Hapana		Tarehe ya kipimo		Matokeo ya kipimo cha 1 cha VVU: "P" Positive, "N" Negative		Amepata unasihi baada ya kupima N = Ndiyo, H = Hapana		Matokeo ya kipimo cha pili cha VVU (P,N)	Amepata ushauri juu ya ulishaji wa mtoto	Matokeo ya MRDT au BS: "P" Positive, "N" Negative	Amepata hati Punguzo: "N" Ndiyo, "H" Hapana	Andika tarehe ya IPT-1	Andika tarehe ya IPT-2	Andika tarehe ya IPT-3	Andika tarehe ya IPT-4	I, FA, IFA 1	I, FA, IFA 2	I, FA, IFA 3	I, FA, IFA 4		Tarehe	Kituo alikopelekwa	Sababu ya rufaa	Kituo alikotokea	
KE	ME	KE	ME	ME	KE	ME	KE	2	3	4	5	6	7	8	9	Ke	Me	Ke	Me	Ke	Me	Ke	Me	Ke	Me	Ke	Me	"P" +ve, "N" -ve	N/H																

REKODI YA MAHUDHURIO YA MAMA BAADA YA KUJIFUNGUA HADI WIKI 6

Baada ya kujifungua mama ahudhurie kliniki mara tatu au zaidi. Chunguza yafuatayo, weka (√) au Ndiyo au Hapana panapohusika. Pale unapogundua tatizo mpeleke kwa Mganga au Hospitali.

A. REKODI YA MAHUDHURIO	Mahudhurio Ndani ya masaa 48	Mahudhurio Ndani ya siku 7	Mahudhurio Ndani ya siku 28	Mahudhurio Ndani ya siku 42
Tarehe:				
Joto la Mwili (38°c na zaidi)				
Blood Preasure 140/100 na zaidi (mmHg)				
Hb chini ya 60% (8.5gm/dl)				
PMTCT: Lishe ya mtoto: Maziwa ya mama pekee (EBF), Maziwa mbadala (RF): Uliza yafuatayo				
Matiti:				
• Mtoto ananyonya?				
• Maziwa yanatoka				
• Ameanza kunyonya ndani ya saa moja				
• Chuchu zina vidonda				
• Yamejaa sana				
• Yana jipu				
• Chunguza unyonyeshaji, toa ushauri				
Tumbo la uzazi:				
• Linanywea? Involution) Ndiyo/Hapana				
• Maumivu makali				
Sehemu za Uke				
Msamba / Kidonda cha upasuaji				
• Msamba: - Hakuchanika: Ndiyo / Hapana				
- Alichanika (Tear)				
- Aliongezwa njia (Episiotomy)				
• Kidonda kimepona? Ndiyo / Hapana				
- Kina usaha: Ndiyo / Hapana				
- Kimeachia: Ndiyo / Hapana				
• Lokia - Inanuka? Ndiyo/Hapana				
- Nyingi / Wastani / Kidogo				
- Rangi gani?				
Hali ya Akili:				
- Mgonjwa / Siyo Mgonjwa				
- Matatizo mengine				
Uzazi wa Mpango:				
• Ushauri umetolewa? Ndiyo/Hapana				
Dawa za Kinga:				
• Ferrous Sulphate				
• Folic Acid				
• Pepopunda: Chanjo amepata ya ngapi? TT1, TT2, TT3, TT4, TT5				
PMTC/CTX - Kama mama anaishi na VVU				
Dawa anazotumia baada ya kujifungua (ART)				
Vitamini A (Amepata/Hajapata)				
Tiba Nyingine				
Tarehe ya Kurudi				
Jina la Mhudumu				
Cheo cha Mhudumu				
SAINI YA MHUDUMU				

***Iwapo mama ana matatizo aonwe kliniki kulingana na mahitaji**

KADI HII HAIUZWI RCH 4

Jamuhuri ya Muungano wa Tanzania
Wizara ya Afya na Ustawi wa Jamii

KADI YA KLINIKI YA WAJA WAZITO

Jaza au weka (√) panapohusika

JINA LA KLINIKI	NAMBA YA UANDIKISHAJI		
	NAMBA YA HATI PUNGUZO YA CHANDARUA		
JINA LA MAMA	UMRI:	KIMO: (CM:)	JUU YA 150 ☐ / CHINI YA 150 ☐
	ELIMU:	KAZI:	
JINA LA MUME / MWENZI	UMRI:	ELIMU:	
	KAZI:		
KIJIJI/MTAA/KITONGOJI:	JINA LA MWENYEKITI:		

HABARI KUHUSU UZAZI ULIOTANGULIA

MIMBA YA NGAPI ..... AMEZAA MARA NGAPI ..... WATOTO WALIO HAI .....

Mimba zilizoharibika	Mwaka	Umri wa mimba	Mimba zilizoharibika	Mwaka	Umri wa mimba
1			3		
2			4		

TAREHE YA KUANZA YA HEDHI YA MARA YA MWISHO (LNMP): .....

TAREHE ANAYOTAZAMIA KUJIFUNGUA (EDD): .....

CHUNGUZA VIDOKEZO VIFUATAVYO KWA MAMA AJAPO KWA MARA YA KWANZA

A **WEKA ALAMA YA (√) PANAPOHUSIKA, MPELEKE KITUO CHA AFYA AU HOSPITALI KWA UCHUNGUZI/USHAURI ZAIDI ENDAPO MAMA ANA**

UMRI CHINI YA MIAKA 20 ☐
MIAKA 10 AU ZAIDI TOKEA MIMBA YA MWISHO ☐
KUJIFUNGUA KWA KUPASULIWA ☐
KUZAA MTOTO MFU/KIFO CHA MTOTO MCHANGA (Wk 1) ☐
KUHARIBIKA KWA MIMBA 2 AU ZAIDI ☐
UGONJWA WA MOYO ☐ KISUKARI ☐ KIFUA KIKUU ☐

B **WEKA ALAMA YA (√) PANAPOHUSIKA, MPELEKE KITUO CHA AFYA AU HOSPITALI KWA KUJIFUNGUA ENDAPO MAMA ANA:**

MIMBA YA 5 AU ZAIDI ☐
KIMO CHINI YA CM 150 ☐
KILEMA CHA NYONGA ☐
MIMBA YA KWANZA ZAIDI YA MIAKA 35 ☐
KUZALISHWA KWA KUPASULIWA AU VACUM ☐
KUTOKA DAMU NYINGI **BAADA** YA KUJIFUNGUA ☐
KONDO LA NYUMA KUKWAMA ☐

VIPIMO MAALUM VYA MAABARA:

DAMU: GROUP ..... Rh ..... SYPHILIS SERO STATUS .....

VIPIMO VINGINE: .....

Toleo 2015 *Iwapo mama ana matatizo aonwe kliniki kulingana na mahitaji

REKODI YA MAHUDHURIO

CHUNGUZA VYOTE KILA MAHUDHURIO MPELEKE KITUO CHA AFYA /HOSPITALI IWAPO KIWANGO KINAZIDI AU KINAPUNGUA ILIYO KWENYE MABANO

Mimba isiyo na matatizo mama anahitaji mahudhurio 4: chini ya wiki 16, kati ya wiki 20-24, 28-32, 36-40*

TAREHE YA MUDHURIO						
UZITO (Kilo)						
BLOOD PREASURE (140/90mmHg)						
ALBUMIN KWENYE MKOJO (+)						
DAMU/Hb (8.5 gm/dl)						
SUKARI KWENYE MKOJO (_)						
UMRI WA MIMBA KWA WIKI						
KIMO CHA MIMBA KWA WIKI						
MLALO WA MTOTO						
KITANGULIZI (KUANZIA WIKI YA 36)						
MTOTO ANACHEZA BAADA YA WIKI 20 (NDIYO/HAPANA)						
MAPIGO YA MOYO WA MTOTO BAADA YA WIKI 20, YAPO (Y), HAKUNA (H)						
KUVIMBA MIGUU (Oedema) (++)						
Ferrous Sulphate (2 kila siku)						
*Folic Acid (1 kila siku)						
MALARIA: Sulphadoxine/Pyrimethmine (SP) vidonge 3 kuanzia wiki ya 14, rudia dose kila hudhurio mradi ipishane wiki 4						
Mebendazole (500gm start)						
PEPOPUNDA: Angalia kadi kama amepata chanjo (jaza amepata ngapi) TT1, TT2, TT3, TT4, TT5						
MAMA AMESHAURIWA KUHUSU:						
• Dalili za Hatari						
• Uzazi wa Mpango						
• Maandalizi ya Kujifungua						
• Magonjwa yatokanayo na kujamiana na matumizi sahihi ya kondomu						
PMTCT:						
• PMTCT/ART (0,-,1,2)						
• Dawa: (ART)						
• CTX- Bila kujali hatua ya ugonjwa						
• Uhusiano na huduma ya CTC (EO, E1, 1R, kama ameandikishwa andika namba ya kadi ya CTC na tarehe						
• Ushauri juu ya lishe ya mtoto: Maziwa ya mama pekee (EBF), Maziwa mbadala (RF)						
• Ufuasi (Adherence): (P= Poor) (G = Good)						
Tarehe ya Kurudi						
Jina la Mhudumu						
Cheo cha Mhudumu						
SAINI YA MHUDUMU						

C **VIDOKEZO VYA MIMBA VYA KUANGALIA KATIKA KILA HUDHURIO. WEKA ALAMA (√) PANAPOHUSIKA NA MPELEKE HOSPITALI KAMA ANA DALILI ZA HATARI**

BP 140/90 AU ZAIDI ..... ☐	UMRI WA MIMBA ZAIDI YA WIKI 40 ..... ☐
Hb Chini ya 60% (8.5gm/dl) ..... ☐	MTOTO KUFIA TUMBONI ..... ☐
ALBUMIN KWENYE MKOJO ..... ☐	MTOTO AMELALA VIBAYA BAADA YA WIKI 36 ..... ☐
SUKARI KATIKA MKOJO ..... ☐	KUVIMBA MIGUU, USO/MIKONO ..... ☐
KAMA ANAZO DALILI ZA HATARI ☐	MAMA ANA MAPACHA ..... ☐
KIMO CHA MIMBA KIKUBWA ZAIDI AU KIDOGO ZAIDI KULIKO UMRI WAKE ..... ☐	
MAMA ANASHAURIWA AZALIE WAPI:	

***Baada ya wiki 40 mama ahudhurie kliniki kila wiki.**

REKODI YA UCHUNGU

JINA LA KITUO .....

KULAZWA Tarehe ..... Saa .....

UCHUNGU UMEANZA: Tarehe ..... Saa .....

CHUPA IMEPASUKA: NDIYO/HAPANA: Tarehe ..... Saa .....

UMRI WA MIMBA: (Wiki) ..... KIMO CHA MIMBA (Wiki) .....

MLALO WA MTOTO ..... KITANGULIZI .....

MPIMAJI WA NYONGA:
- Sacral Promontory inafikiwa? Ndiyo / Hapana
- Ischial Spines zimejitokeza? Ndiyo / Hapana
- Outlet: Finyu? Ndiyo / Hapana
- Nyonga ni kubwa ya kutosha? Ndiyo / Hapana

MAONI YA MPIMAJI: .....

JINA LA MHUDUMU: ..... CHEO .....

CHUNGUZA VIDOKEZO HIVI WAKATI WA KUMLAZA. WEKA ALAMA (√) PANAPOHUSIKA. MPELEKE HOSPITALI AU MWARIFU DAKTARI HARAKA.

KIDOKEZO AAU B KATIKA UJAUZITO	☐	HOMA ZAIDI YA 38 Centigrade	☐
CHUPA IMEPASUKA BILA UCHUNGU	☐	KONDO LA NYUMA KUKWAMA	☐
UCHUNGU KABLA YA WIKI 34	☐	KIFAFA CHA MIMBA AU BP ZAIDI YA 140/90	☐
NI ZAIDI YA SAA 12 TOKEA UCHUNGU ULIPOANZA	☐	UPUNGUFU WA DAMU CHINI YA (8.5gm/dl)	☐
MLALO TANGULIZI KIBAYA CHA MTOTO	☐	NYONGA NYEMBAMBA UA MTOKO MKUBWA	☐
KUTOKA DAMU UKENI	☐	MECONIUM	☐
MAPIGO YA MOYO YA MTOTO YANABADILIKA BADILIKA (Chini ya 120 au zaidi ya 160 kwa dakika)	☐		

BAADA YA KUZAA

KUCHANIKA VIBAYA KWA MSAMBA	☐	KUPOTEZA DAMU ZAIDI YA ML 500	☐
DAWA YA MACHO (EYE OINTMENT) IMETOLEWA NDIYO ☐ HAPANA ☐		VITAMINI A IMETOLEWA: NDIYO/HAPANA	

MAELEZO YA UZAZI

KUJIFUNGUA: Tarehe ..... Saa .....

NJIA YA KUJIFUNGUA .....

KAMA AMEPASULIWA: SABABU ZA KUPASULIWA .....

KONDO LIMETOKA: Tarehe ..... Saa .....

KONDO NA MEMBRENI ZIMETOKA KAMILI? NDIYO/HAPANA .....

DAMU ILIYOTOKA ..... ML ERGOMETRINE/OXTOCIN ..... I.M

MSAMBA: HAUKUCHANIKA ☐ UMECHANIKA ☐ ULICHANWA (EPISIOTOMY) ☐

JINA LA ALIYESHONA MSAMBA ..... CHEO .....

BP BAADA YA KUJIFUNGUA ..... (mmHg)

MUHTASARI: HATUA YA 1 Saa ..... Dakika ..... HATUA YA 2 Saa ..... Dakika .....
HATUA YA 3 Saa ..... Dakika.....

JINA LA MZALISHAJI ..... SAINI .....

MENGINEYO MUHIMU..... ARVs Baada ya kujifungua ☐ ART ☐ Hakunywa

MTOTO: Jinsia ..... Uzito ..... Kgs

APGAR SCORE 1 dakika ..... 5 dakika .....

Kama mama ni PMTCT1, Je, mtoto amepewa ARVs ☐N ☐ Hakunywa (ndani ya masaa 72)
NVP dispensed ☐ 1 wk ☐ 4 wk

Lishe ya mtoto: Maziwa ya mama pekee EBF ☐ Maziwa mbadala RF ☐ Huduma ya unasihi ya kusaidia ulishaji wa watoto wachanga ☐

VIDOKEZO VYA HATARI KWA MTOTO BAADA YA KUZALIWA

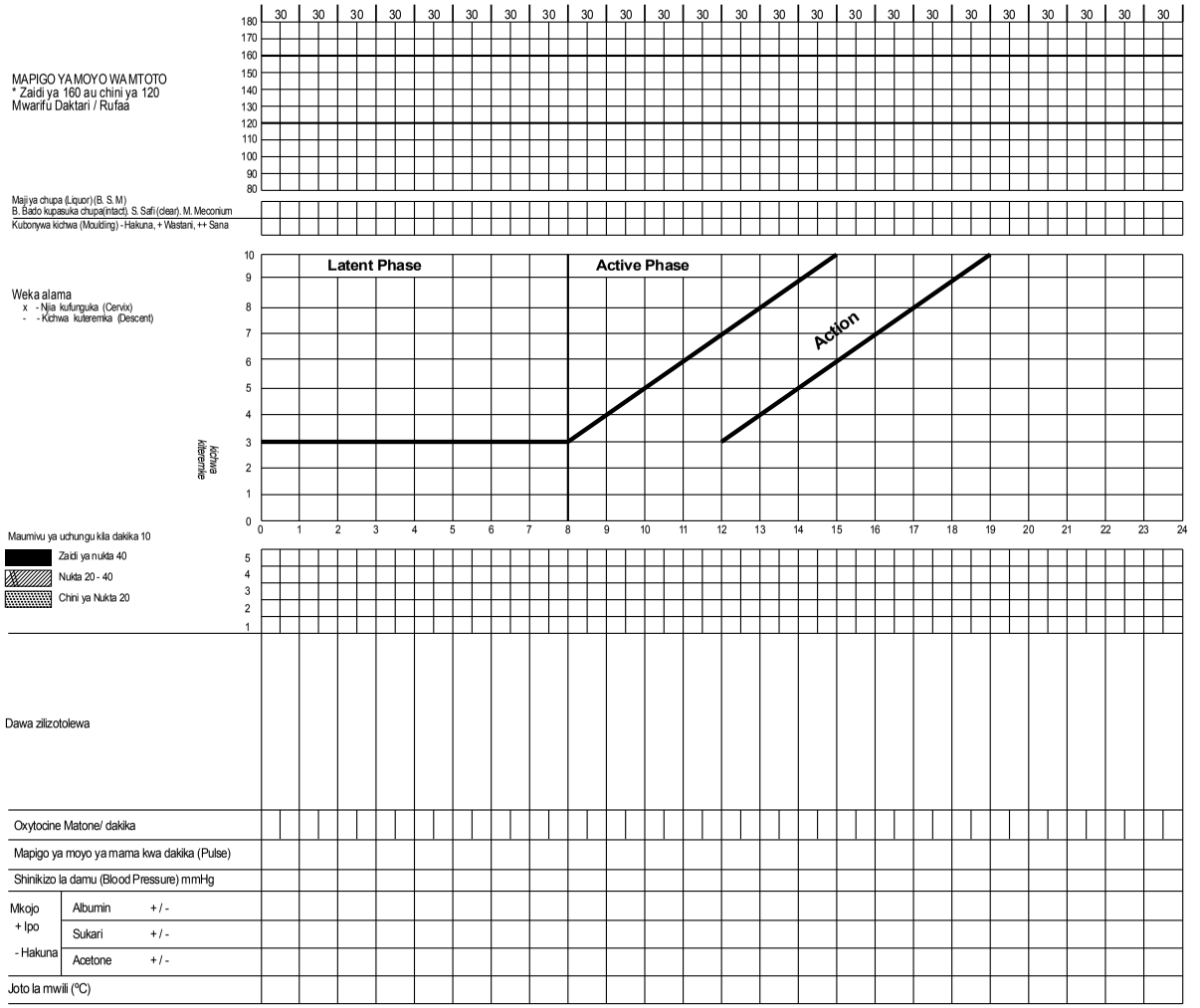
***Weka alama ya (√) panapohusika. Mpeleke hospitali**

Uzito chini ya kilo 2.5 ☐ Homa kali zaidi ya Nyuzi 38°C ☐ Mtoto kushindwa kunyonya ☐
Mtoto kushindwa kupumua vizuri (APGAR SCORE chini ya 5 baada ya dakika 5) ☐
Chunguza maumbile ya mtoto tokea kichwani hadi miguuni

*Kama mtoto amezaliwa na mama aliye na kaswende amepatiwa matibabu

Grafu ya Uchungu

TAREHE _____ SAA _____



"SIRI"

JAMHURI YA MUUNGANO WA TANZANIA

WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA

MTUHA TOLEO LA TATU: MWAKA 2014

KITABU CHA 7: REJESTA YA WATOTO

Jina la Kituo..... Wilaya..... Mkoa.....

Tarehe ya Kuanza..... Tarehe ya Kumaliza.....

MWONGOZO JINSI YA KUJAZA REJISTA YA WATOTO

Safu ya (1): Na. Andika namba ya mteja ukianzia na 0001

Safu ya (2): Tarehe mtoto aliyoonwa kwa mara ya kwanza: Tarehe iandikwe kwa tarakimu mbili na herufi tatu za mwezi mfano 03 Jan

Safu ya (3): Namba ya Utambulisho anayopewa mtoto: Namba ya utambulisho ina sehemu mbili. Sehemu ya kwanza ni tarakimu mbili za mwisho wa mwaka. Kwa hiyo, 2014 itaandikwa 14 kwa kila mtoto atakayeandikishwa mwaka huo, na hii itajazwa sehemu ya kwanza ya safu hii. Sehemu ya pili ni namba ya kuandikishwa. Kila mtoto apewe namba zinazofuatana kuanzia namba moja.

Safu ya (4): Namba ya usajili wa kuzaliwa kutoka vizazi na vifo (Birth Registration No): Safu hii ijazwe mara tu mtoto atapokuwa amesajiliwa.

Safu ya (5): Jina kamili la mtoto: Andika majina matatu.

Safu ya (6): Tarehe ya kuzaliwa: Andika tarehe ya kuzaliwa mtoto mfano 07 Nov 14 (ikimaanisha tarehe saba mwezi wa kumi na moja mwaka 2014).

Safu ya (7): Mahali anapoishi: Andika Jina la sehemu anapoishi ndani ya mtaa au kijiji chake au Jina la mwenyekiti wa kitongoji (kama kitongoji, barabara nk. Mfano ubungo-msewe au buguruni-malapa)

Safu ya (8): Jinsi ya mtoto: Andika "KE" kama ni wa kike na "ME" kama ni wa kiume.

Safu ya (9): Taarifa za mama: Andika jina kamili la mama (Majina matatu).

Hali ya chanjo ya pepo punda (TT) kwa mama mjamzito. Mama atakuwa amekingwa iwapo atakuwa amepata chanjo ya Pili ya TT wiki mbili kabla ya kujifungua. Iwapo kadi inaonesha kuwa mama amekingwa andika herufi "N", Iwapo kadi inaonesha hajakingwa andika herufi "H". Andika alama ya "U" iwapo mama hajaleta kadi na kwa hiyo hali yake ya chanjo haijulikani.

Hali ya maambukizo ya VVU kutoka kwa mama kwenda kwa mtoto; Andika "1" kama ni Positive, "2" kama ni Negative, "U" kama amepima lakini hakuchukua majibu na dashi "–" kama hakupima.

Safu ya (10): Andika namba ya utambulisho ya mtoto aliyezaliwa na mama mwenye VVU (HIV Exposed Identification no. (HEID no.)

Safu ya (11). Tarehe ya chanjo: Andika tarehe mtoto aliyopata chanjo ya BCG na OPV0. Andika siku na mwezi mfano 0711 (ikimaanisha tarehe saba mwezi wa kumi na moja).

Safu ya (12): Tarehe ya chanjo ya PENTA valent: Andika tarehe mtoto atakapopewa chanjo ya PENTA 1, 2 na 3. Andika siku na mwezi mfano 0711 (ikimaanisha tarehe saba mwezi wa kumi na moja).

Safu ya (13): Tarehe ya chanjo ya Polio: Andika tarehe mtoto atakapopewa chanjo ya Polio1, 2 na 3. Andika siku na mwezi mfano 0711 (ikimaanisha tarehe saba mwezi wa kumi na moja).

Safu. ya (14): Tarehe ya chanjo ya Pneumococcal (PCV 13): Andika tarehe mtoto atakapopewa chanjo ya PCV13 1, 2, na 3. Andika siku na mwezi mfano 0711(ikimaanisha tarehe saba mwezi wa kumi na moja).

Safu ya (15): Tarehe ya chanjo ya Rota: Andika tarehe mtoto atakapopewa chanjo ya Rota1 na 2. Andika siku na mwezi mfano 0711 (ikimaanisha tarehe saba mwezi wa kumi na moja).

Safu ya (16): Tarehe ya chanjo ya Surua/Rubella: Andika tarehe mtoto atakapopewa chanjo ya Surua/ Rubella. Andika siku na mwezi mfano 0711 (ikimaanisha tarehe saba mwezi wa kumi na moja)

Safu ya (17) Vitamin A: Hutolewa kwa mtoto kuanzia umri wa miezi 6 na kurudia kila baada ya miezi 6. Andika "N" iwapo amepewa vitamin A na "H" iwapo hakupewa.

Safu ya (18): Ukuaji wa mtoto: Andika ukuaji wa mtoto katika umri wa miezi 9, 18, 36 na 48. Safu itarekodi ukuaji wa mtoto, ikijumuisha; uwiano wa uzito kwa umri, uzito kwa urefu na urefu kwa umri.

Uwiano wa uzito kwa umri: (Kwa kutumia RCH kadi namba 1)
Andika 1 iwapo uwiano ni zaidi ya asilimia 80 (>80%); 2 iwapo uwiano ni kati ya asilimia 60 na 80; 3 kama uwiano n ichini ya asilimia 60 (<60%).
NB: Iwapo kituo kimeshaanza kutumia chati mpya za watoto, Andika 1 iwapo uwiano ni zaidi ya -2SD (>-2SD, yaani juu ya mstari wa -2SD); (>-2SD, yaani juu ya mstari wa -2SD) 2 iwapo uwiano ni kati ya -2SD na -3SD; 3 kama uwiano ni chini ya -3 SD(<-3SD),

Uwiano wa uzito kwa urefu, urefu kwa Umri na uzito kwa Umri:
Andika 1 iwapo uwiano ni zaidi ya -2SD (>-2SD); 2 iwapo uwiano ni kati ya -2SD na -3SD; 3 kama uwiano ni chini ya -3 SD(<-3SD)

Safu ya (19): Mebendazole/Albendazole kila miezi sita: Mtoto mwenye umri wa mwaka mmoja au zaidi apewe dawa za minyoo kila baada ya miezi 6. Andika "N" kama mtoto amepewa Mebendazole/ Albendazole katika miezi 6 iliyopita, au "H" endapo mtoto hajapewa.

Safu ya (20): Hati punguzo ya chandarua: Hutolewa kwa watoto wanapopata chanjo ya PENTA1. Andika "N" kama mtoto amepatiwa hati punguzo na endapo mtoto hajapatiwa hati punguzo acha wazi

Safu ya (21): Ulishaji wa mtoto: Umri – Andika "N" (Ndiyo) iwapo mtoto bado ananyonya maziwa ya mama pekee pasipo kupewa hata maji katika umri wa miezi sita. Andika "H" (Hapana) kama mtoto alikwisha anzishiwa vinywaji na vyakula vingine kabla ya miezi sita. Andika "RF"- endapo mtoto aliyezaliwa na mama mwenye VVU anapewa maziwa mbadala.

Safu ya (22): Rufaa: Kama mtoto amepata rufaa;

i. Andika jina la kituo alipotoka mtoto
ii. Andika jina la kituo alipopelekwa mtoto kwa rufaa mfano ngazi ya juu ya huduma
iii. Andika sababu ya kupewa rufaa mfano matibabu zaidi kwa mtoto, kuhamishiwa kliniki ya huduma na matibabu kwa wenye VVU (CTC)

Safu ya (23):Maelezo mengineyo/ maoni: Andika maelezo ya ziada mfano; mtoto amehama, amefariki, hakuna taarifa; endapo hakuna taarifa, jitihada za kumfuatilia mtoto zifanyike.

1	2	3		4	5	6	7	8	9			10	11		12		
Na.	Tarehe	Namba ya Utambulisho		Namba ya usajili wa vizazi (Birth registration)	Jina la Mtoto	Tarehe ya kuzaliwa	Mahali Anapoishi (Kitongoji/ Mtaa) au Jina la mwenyekiti wa kitongoji	Jinsi (KE/ME)	Taarifa za Mama			(HEID no)	Tarehe ya Chanjo		Tarehe ya Chanjo ya PENTA		
		Mwaka	Namba						Jina la Mama	Ana kinga ya pepopunda a (TT2+)? N / H /U	Hali ya VVU 1 2 U -		BCG	OPVO	1	2	3

13			14			15		16		17			18												19				20	21		22			23
Tarehe ya Chanjo ya Polio			Tarehe ya Chanjo Pneumococcal (PCV13)			Tarehe ya chanjo ya Rota		Tarehe ya chanjo ya Surua/Rubella		Vitamini A			Ukuaji wa mtoto (1=>80% au >-2SD, 2=80% au-2SD–3 SD; 3=<60% au <-3 SD)											Mebendazole / Albendazole kila miezi 6				Hali punguzo chandarua	Ulishaji wa mtoto		Rufaa			Maelezo mengineyo/ maoni
1	2	3	1	2	3	1	2	1	2	Miezi 6	chini ya mwaka	mwaka 1-5	Uzito/ umri	Uzito/ urefu	Urefu/ umri	Uzito/ umri	Uzito/ urefu	Urefu/ umri	Uzito/ umri	Uzito/ urefu	Urefu/ umri	Uzito/ umri	Uzito/ urefu	Urefu/ umri	Miezi 12	Miezi 18	Miezi 24	Miezi 30	H N	Maziwa ya mama pekee (EBF) N H (Mtoto umri miezi 6)	Maziwa mbadala (N H)	Andika kituo alikotoka mtoto	Kituo alikopelekwa	Sababu ya rufaa	Mfano; hakuna taarifa, amehama au amefariki
										N/H	N/H	N/H																								

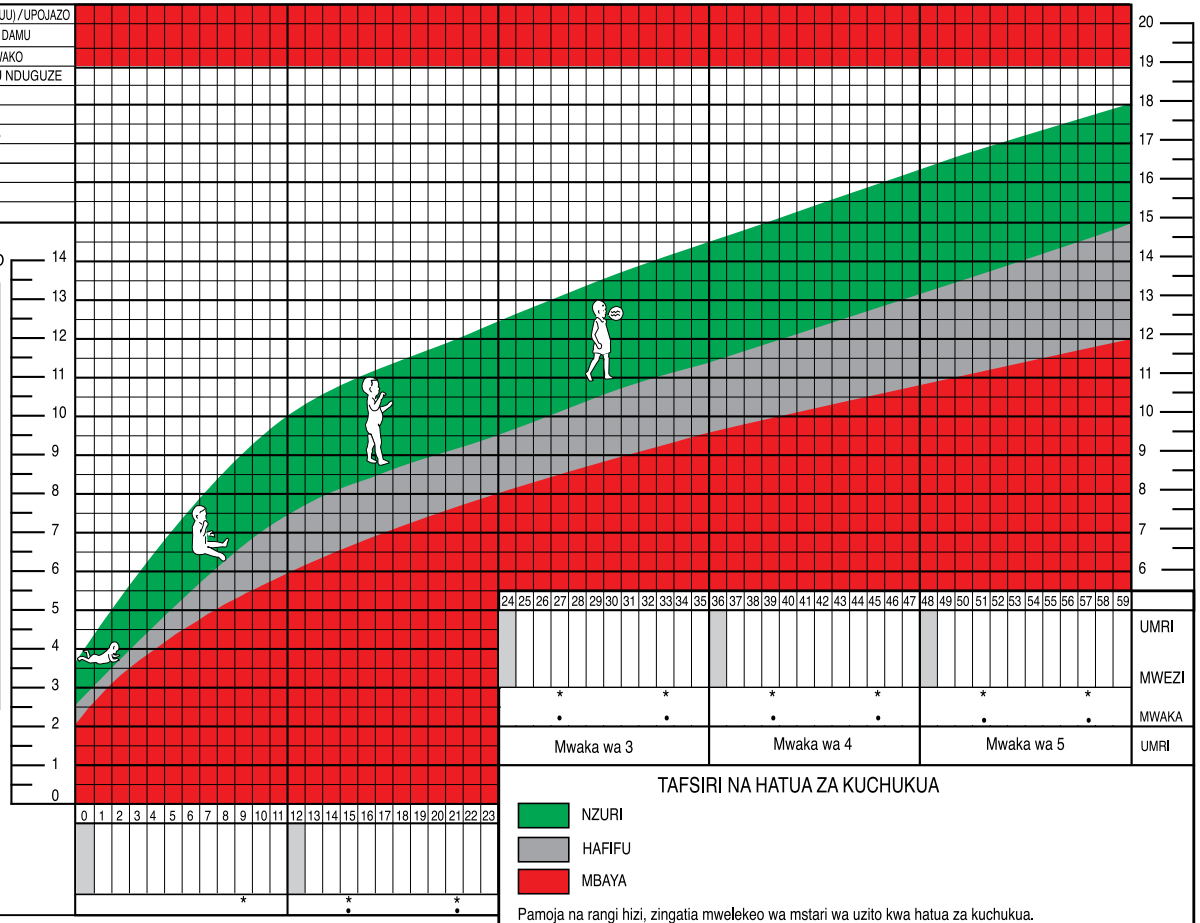
UKUAJI NA MAENDELEO YA MTOTO

VIDOKEZO VYA HATARI: CHUNGUZA VYOTE KATIKA KILA HUDHURIO, WEKA ALAMA (V) AU JAZA PANAPOHUSIKA KISHA UMSHAURI MAMA/MLEZI AMPELEKE KWA MGANGA/KITUO CHA AFYA/HOSPITALI INAPOHITAJIKA

MPELEKE KWA MGANGA	
	UNYAFUZI (KUVIMBA MIGUU) / UPOJAZO
	UPUNGUFU MKUBWA WA DAMU
	MAGONJWA MAGUMU KWAKO
ANAYETUNZWA NA MZAZI MMOJA AU NDUGUZE	
NDUGUYE ANA UTAPIAMLO	
ALIUGUA KARIBUNI	
HAKUONGEZEKA UZITO KWA MIEZI 3	
AMEPUNGUA UZITO	
HANYONYESHWI MAZIWA YA MAMA	
UMRI CHINI YA MIEZI 6, AMELIKIZWA	
UMRI JUU YA MIEZI 6, HAJALIKIZWA	

VIDOKEZO VYA AWALI
CHUNGUZA VYOTE HUDHURIO LA KWANZA

- UZITO WA KUZALIWA CHINI YA GRAM 2500 ☐
- MTOTO WA 4 AU ZAIDI ☐
- PACHA ☐
- YATIMA ☐
- VIFO VYA NDUGUZE CHINI YA MIAKA MITANO ☐



UMRI WA MTOTO (MIEZI)
Andika mwezi wa kuzaliwa katika visanduku vyote vitano vyeusi katika hudhurio la kwanza
*Apewe Vitamin A tu
*Apewe vitamin A na dawa za Minyoo

TAFSIRI NA HATUA ZA KUCHUKUA

- NZURI
- HAFIFU
- MBAYA

Pamoja na rangi hizi, zingatia mwelekeo wa mstari wa uzito kwa hatua za kuchukua.

- MTOTO ANAENDELEA KUKUA VIZURI; Mpongeze Mzazi
- MTOTO HAONGEZEKI UZITO; Mchunguze mtoto, toa ushauri wa lishe na utunzaji wa mtoto
- MTOTO ANAPUNGUA UZITO; Apelekwe kwa Mganga kwa uchunguzi zaidi

*** Katika umri huu mtoto apewe Vitamin A na dawa ya Minyoo**

MWAKA	Mwaka wa 1			Mwaka wa 2	
	Hali ya Mama	ARVs Wakati wa ujazito		ARVs Wakati wa kujifungua	ARVs baada ya kujifungua
PMTCT - Mama	☐U ☐1 ☐2	☐ Anaendelea na tiba (ART) ☐ Ameanza tiba (ART) Ujauzito huu		☐ Anaendelea na tiba (ART) ☐ Ameanza tiba (ART)	☐ Anaendelea na tiba (ART) ☐ Ameanza tiba (ART)
	Dawa ya kinga NVP	Umri (m/wks)			CNF (Umri)
PMTCT - Mtoto	Amepewa ☐ <Wk6	Hakupewa ☐	Kipimo (Ab/PCR)		
			Matokeo (1au 2)		
Alipoanza kupewa Cotimoxazole	Wiki ya 6 (N/H)		Wiki nyingine alizopewa		
Kipimo baada ya kuacha kunyonya (Ab/PCR)					
					Rufaa CTC: ☐N ☐H
Hati punguzo	No :		Tarehe :	CTC No.	

UFUATILIAJI WA MTOTO MCHANGA SIKU 0 - 42

WEKA (√) KAMA NDIYO; (X) KAMA HAPANA
CHUNGUZA YAFUATAYO UNAPOGUNDUA TATIZO MPELEKE KWA MGANGA

MAHUDHURIO	HUDHURIO LA KWANZA (NDANI YA MASAA 24)	HUDHURIO LA PILI (NDANI YA SIKU 7)	HUDHURIO LA TATU (NDANI YA SIKU 28)	HUDHURIO LA NNE (NDANI YA SIKU 42)
Tarehe				
Uzito (Kilo)				
Upungufu wa wekundu wa damu (Hb)				
Joto la mwili				
LISHE YA MTOTO				
Maziwa ya Mama pekee (EBF) Maziwa mbadala (RF)				
Angalia kuchezacheza kwa mtoto je, ni kidogo kuliko kawaida ?				
Macho - yatoa uchafu				
Mdomo - Una utando mweupe				
KITOVU				
- kimepona				
- Chekundu				
- Kinatoa harufu / usaha				
Ngozi				
- Ina vipele vyenye usaha				
- Imebadilika kuwa ya njano				
CHANJO				
- Amepata BCG				
- Amepata Polio 0				
- Amepata Polio 1				
- Amepata DPT - HepB - Hib				
- Amepata Pneumococcal				
- Amepata Rota				
Tarehe ya kurudi				
Jina la Mhudumu:				
Cheo cha Mhudumu:				

Eleza matatizo mengine

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LAZIMA MTOTO APIMWE UZITO KILA MWEZI.

TAREHE	HALI YA UKUAJI NA MAENDELEO YA MTOTO	RUDI TAREHE

Toleo la 2015 Mtoto apimwe uzito kila mwezi

TAREHE	HALI YA UKUAJI NA MAENDELEO YA MTOTO	RUDI TAREHE

Lazima mtoto apate cheti cha kuzaliwa kutoka kwa Msajili wa Vizazi na Vifo

KADI HII HAIUZWI

RCH 1

Jamhuri ya Muungano wa Tanzania

Wizara ya Afya na Ustawi wa Jamii

KADI YA KLINIKI YA MTOTO

Jina la Kliniki	**Na. ya Mtoto**
Jina la Mtoto	**Mume / Mke**
Tarehe ya Kuzaliwa;...................... Uzito wa Kuzaliwa (Grams): (Kilo)	
Mahali Alipozaliwa Hospitalini / Nyumbani / Njiani	
Aina ya Mhudumu aliyemzalisha Mtumishi wa afya/TBA/ Wengineo	
Jina la Mama / Mlezi	
Jina la Baba / Mlezi	
Namba ya simu	
Mahali Mtoto Anapoishi Sasa Mtaa:.. Kijiji:.. Kitongoji:..	

CHANJO	**(Andika Tarehe aliyopata)**			
AINA YA CHANJO	Anapozaliwa au mara ya kwanza afikapo kliniki	Kuna kovu (√)		Marudio miezi 3 kama kovu hakuna
BCG (Kifua Kikuu) ***Sindano Bega kulia***				
	0 Anapozaliwa	1 (Wiki 6)	2 (Wiki 10)	3 (Wiki 14)
POLIO (Kupooza) - OPV **(Matone - Mdomoni)**				
POLIO (Kupooza) - IPV **(Sindano - Paja la kulia)**				
DTP-Hep B- Hib (Donda koo, Kifaduro, Pepopunda na Hepatitis B) **(Sindano - Paja la kushoto)**				
PCV13- (Nimonia) **(Sindano - Paja la kulia)**				
ROTARIX - (Kuharisha) **(Matone - Mdomoni)**				
SURUA RUBELLA (MR) **(Sindano - Bega la kushoto)**	Miezi 9		Miezi 18	

VITAMINI A NA DAWA ZA MINYOO (Weka alama ya √ kwenye mwezi husika)

VITAMINI A	6	12	18	24	30	36	42	48	54
Matone/Mdomoni									
DAWA ZA MINYOO		12	18	24	30	36	42	48	54
Vidonge - Mdomoni									

Fuatilia, chunguza, shauri kuhusu Lishe ya Mtoto katika kila hudhurio

"SIRI"

JAMHURI YA MUUNGANO WA TANZANIA
WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA

MTUHA TOLEO LA TATU: MWAKA 2014

FOMU YA TAARIFA YA KITABU CHA 6: REJESTA YA WAJAWAZITO

Jina la Kituo..... Wilaya.....

Tarehe ya Kuanza..... Tarehe ya Kumaliza.....

Taarifa ya Mwezi Toka Kliniki (ANC)

Jina la Kituo .....Wilaya…….……. Mwezi.....Mwaka.....

Namba	Maelezo	Umri <Miaka 20	Umri Miaka 20 na zaidi	Jumla
1	Idadi ya Wajawazito Waliotegemewa			
2	**Hudhurio la kwanza**			
2a	Umri wa mimba chini ya wiki 12 (< 12weeks)			
2b	Umri wa mimba wiki 12 au zaidi (12+ weeks)			
	Jumla ya hudhurio la Kwanza (2a+2b)			
2c	Wateja wa marudio			
2d	Hudhurio la nne wajawazito wote			
	Jumla ya Mahudhurio yote (2c+2d)			
2e	Idadi ya wajawazito waliopima damu hudhurio la kwanza			
3	Wajawazito waliopata Chanjo ya TT2+			
4	**Vidokezo vya Hatari**			
4a	Mimba zaidi ya 4			
4b	Umri chini ya miaka 20			
4c	Umri zaidi ya miaka 35			
4d	Upungufu mkubwa wa damu <8.5g/dl – Anaemia hudhurio la kwanza			
4e	Shinikizo la damu (BP =>140/90mm/hg)			
4f	Kifua kikuu			
4g	Sukari kwenye mkojo			
4h	Protein kwenye mkojo			
4i	Waliopima Kaswendwe			
4j	Waliogundulika na maambukizi ya Kaswende			
4k	Waliopata matibabu ya Kaswende			
4l	Wenza/Waume waliopima Kaswende			
4m	Wenza/Waume Waliogundulika na maambukizi ya Kaswende			
4n	Wenza/waume waliopata matibabu ya Kaswende			
4o	Waliopatikana na magonjwa ya mambukizo ya ngono yasio kaswende			
4p	Waliopata tiba sahihi ya magonjwa ya mambukizo ya ngono yasio kaswende			
4q	Wenza/waume waliopatikana na magonjwa ya mambukizo ya ngono yasio kaswende			
4r	Wenza/waume waliopata tiba sahihi ya magonjwa ya ngono yasio kaswende			
5	**PMTCT**			
5a	Tayari wana maambukizi ya VVU kabla ya kuanza kliniki			
5b	Wajawazito wote waliopata ushauri nasaha kabla ya kupima VVU kliniki			

Namba	Maelezo	Umri <Miaka 20	Umri Miaka 20 na zaidi	Jumla
5c	Wajawazito Waliopima VVU kipimo cha kwanza kliniki			
5d	Wajawazito Waliokutwa na VVU (positive) kipimo cha kwanza			
5e	Wajawazito Waliokutwa na VVU (positive) kipimo cha kwanza walio chini ya umri wa miaka 25			
5f	Wajawazito waliopata ushauri baada ya kupima			
5g	Wajawazito walipiomwa VVU na wenza wao (Couple) kwa pamoja katika kliniki ya wajawazito			
5h	Wajawazito waliopima VVU kipimo cha pili			
5i	Wajawazito waliokutwa na maambukizi ya VVU kipimo cha pili			
5j	Wenza waliopima VVU kipimo cha kwanza Kliniki ya wajawazito			
5k	Wenza waliogundulika kuwa na maambukizi ya VVU kipimo cha kwanza katika kliniki ya wajawazito			
5l	Wenza waliopima VVU kipimo cha pili Kliniki ya wajawazito			
5m	Wenza waliogundulika kuwa na maambukizi ya VVU kipimo cha pili katika kliniki ya wajawazito			
5n	Wajawazito na wenza waliopata majibu tofauti (discordant) baada ya kupima VVU kliniki ya wajawazito			
5o	Waliopata ushauri juu ya ulishaji wa mtoto			
6	**Malaria**			
6a	Waliopewa vocha ya hati punguzo			
6b	Waliopima Malaria kutumia MRDT			
6c	Waliopima Malaria positive			
6d	Waliopewa IPT2			
6e	Waliopewa IPT4			
	Huduma Nyingine			
7	Waliopewa Iron/Folic Acid (I,F,IFA) vidonge vya kutosha mpaka udhurio linalofuata			
8	Waliopewa Dawa za minyoo (Albendazole / Mebendazole)			
9	Waliopewa rufaa wakati wa ujauzito			
10	Waliopewa rufaa kwenda CTC			

Jina la Mtayarishaji wa Ripoti..... Cheo.....Wadhifa.....

Tarehe ya kuandaa...../...../..... Imepitiwa na ....., ...

....., ..., ...

Namba ya simu ya kituo..... Taarifa imepokelewa wilayani tarehe...../...../.....

"SIRI"

JAMHURI YA MUUNGANO WA TANZANIA

WIZARA YA AFYA NA USTAWI WA JAMII

MFUMO WA TAARIFA ZA UENDESHAJI WA HUDUMA ZA AFYA

MTUHA TOLEO LA TATU: MWAKA 2014

FOMU YA TAARIFA YA KITABU CHA 7: REJESTA YA WATOTO

Jina la Kituo..... Wilaya..... Mkoa.....

Tarehe ya Kuanza..... Tarehe ya Kumaliza.....

Ripoti ya Mwezi ya Ufuatiliaji wa Watoto

Na.	Maelezo		Idadi		
			ME	KE	Jumla
1	Idadi ya watoto walioandikishwa na kupewa vyeti vya kuzaliwa				
2	**Aina ya Chanjo kwa Umri**				
2a	BCG Umri mwaka <1 (Ndani ya eneo la huduma)				
2b	BCG Umri mwaka 1+ (Ndani ya eneo la huduma)				
2c	BCG Umri mwaka <1 (Nje ya eneo la huduma)				
2d	BCG Umri mwaka 1+ (Nje ya eneo la huduma)				
2e	Polio Umri mwaka <1 (Ndani ya eneo la huduma)	Dozi 0			
		Dozi 1			
		Dozi 2			
		Dozi 3			
2f	Polio Umri mwaka 1+ (Ndani ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2g	Polio Umri mwaka <1(Nje ya eneo la huduma	Dozi 0			
		Dozi 1			
		Dozi 2			
		Dozi3			
2h	Polio Umri mwaka 1+ (Nje ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2i	Polio ya sindano Miezi 18 (Ndani ya eneo la huduma)	Dozi 1			
2j	Polio ya sindano miezi 18 (Nje ya eneo la huduma)	Dozi 1			
2k	Rota umri wiki 6 hadi 15 (Ndani ya eneo la huduma)	Dozi 1			
2l	Rota umri wiki 6 hadi 15 (Nje ya eneo la huduma	Dozi1			
2m	Rota umri wiki 10 hadi 32 (Nje ya eneo la huduma)	Dozi 2			
2n	Rota umri wiki 10 hadi 32 (Ndani ya eneo la huduma	Dozi2			
2o	PENTA Umri mwaka <1 (Ndani ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2p	PENTA Umri mwaka 1+ (Ndani ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2q	PENTA Umri mwaka <1 (Nje ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2r	PENTA Umri mwaka 1+ (Nje ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2s	Pneumococcal (PCV13) <1 (Ndani ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi 3			
2t	Pneumococcal (PCV13) 1+ (Ndani ya eneo la huduma)	Dozi 1			
		Dozi 2			
		Dozi3			
2u	Pneumococcal (PCV13)< 1 (Nje ya eneo la huduma)	Dozi 1			
		Dozi2			
		Dozi 3			
2v	Pneumococcal (PCV13) 1+ (Nje ya eneo la huduma)	Dozi 1			
		Dozi2			
		Dozi 3			
2w	Surua/ Rubela umri miezi 9 (Ndani ya eneo la huduma)	Dozi 1			
2x	Surua/ Rubela umri miezi 9 (Nje ya eneo la huduma)	Dozi 1			
2y	Surua/Rubella umri miezi 18 (Ndani ya Eneo la huduma)	Dozi 2			
2z	Surua/ Rubela umri miezi 18 (Nje ya eneo la huduma)	Dozi 2			
3	**Hali ya Chanjo ya Pepo punda kwa mama wakati wa kujifungua**				
	Idadi ya watoto walioandikishwa	**ME**	**KE**		**Jumla**
3a	Waliokingwa				
3b	Wasiokuwa na Kinga				
3c	Haijulikani				
4	**Mahudhuri na uwiano wa uzito, umri na urefu; umri chini ya mwaka 1**				
	Maelezo		**ME**	**KE**	**Jumla**
4a	Jumla ya Mahudhurio ya Watoto				
4b	Uwiano wa uzito kwa umri	>80% au >-2SD			
		60-80% au -2 hadi -3SD			
		<60% au <-3SD			
4c	Uwiano wa uzito kwa urefu	>-2SD			
		-2 hadi -3SD			
		<-3SD			
4d	Uwiano wa urefu kwa umri	>-2SD			
		-2 hadi -3SD			
		<-3SD			
5	**Mahudhuri na uwiano wa uzito, umri na urefu; umri mwaka 1 mpaka 5**				
5a	Jumla ya mahudhurio				
5b	Uwiano wa uzito kwa umri	>80% au >-2SD			
		60-80% au -2 hadi -3SD			
		<60% au <-3SD			
5c	Uwiano wa uzito kwa urefu	>-2SD			
		-2 hadi -3SD			
		<-3SD			
5d	Uwiano wa urefu kwa umri	>-2SD			
		-2 hadi -3SD			
		<-3SD			

6. Nyongeza ya Vitamini A

	Maelezo	ME	KE	Jumla
6a	Watoto umri wa miezi 6			
6b	Watoto chini ya umri wa mwaka 1			
6c	Watoto umri zaidi ya mwaka 1 - 5			

7. Waliopewa Mebendazole/ Albendazole

	Maelezo	ME	KE	Jumla
7a	Watoto umri wa mwaka 1 hadi 5			

8. Ulishaji wa Watoto Wachanga

	Maelezo	ME	KE	Jumla
8a	Watoto wachanga wanaonyonya maziwa ya mama pekee (EBF)			
8b	Watoto wachanga wanaopewa maziwa mbadala (RF)			

9. Taarifa za PMTCT / waliopewa hati punguzo

	Maelezo	ME	KE	Jumla
9a	Watoto waliozaliwa na mama mwenye maambukizi ya VVU/ watoto wenye HEID no.			
9b	Watoto waliohamishiwa Kliniki ya huduma na matibabu kwa wenye VVU (CTC)			
9c	Watoto waliopatiwa hati punguzo ya chandarua			

Jina la Mtayarishaji wa Ripoti …….. Kada ……..... Wadhifa…..... Sahihi……..……

Tarehe ...../...../.....Imepitiwa na ....., ..., ...

Namba ya simu ya Kituo/Wilaya/ Mkoa .....Taarifa imepokelewa Wilayani tarehe ...../...../.....

Mtwara District Council District Report - November 2015

LLNs Distribution Status

S/N	Indicator	Statistics
1	% of pregnant women who received LLINs in their 1st ANC Visit	78
2	% of Children receiving measles vaccine who also received LLINs	51

Basic Health Indicators

#	Indicator	Statistics
1	Target # of women attending first ANC visit during pregnancy	485
2	Actual # of women attending first ANC visit during pregnancy	299
3	Actual # of women who received LLINs in their first ANC visit during pregnancy	235
4	Target # of children who are supposed to receive Measles 1 - Vaccine	350
5	Actual # of women who received LLINs in their Measles 1 - Vaccine	472
6	Actual # of children who received who received measels 1 - vaccine and an LLIN	472
7	Total # of LLINs distributed through ANC & IVD (source: HMIS/MTUHA)	501

Number of Facilities Reporting and Not Reporting by Type

		Facilities Reporting		Facilities Not Reporting	
S/N	Type	ANC	Child Health Reporting	ANC	Child Health Reporting
1	Dispensary	100.0 %	100.0 %	0.0 %	0.0 %
2	Health Centre	100.0 %	100.0 %	0.0 %	0.0 %
3	Hospital	0 %	0 %	100.0 %	100.0 %

Reviewed by

Name:----------

Title:----------

Signature:----------

Date:----------

Approved by

Nme:----------

Title:----------

Signature:----------

Date:----------

Mtwara District Council District Report - July - September 2015

LLNs Distribution Status

S/N	Indicator	Statistics
1	% of pregnant women who received LLINs in their 1st ANC Visit	77
2	% of Children receiving measles vaccine who also received LLINs	52
3	consumption difference between eLMIS - HMIS (ANC and Child Health)	90

Basic Health Indicators

#	Indicator	Statistics
1	Target # of women attending first ANC visit during pregnancy	1359
2	Actual # of women attending first ANC visit during pregnancy	962
3	Actual # of women who received LLINs in their first ANC visit during pregnancy	742
4	Target # of children who are supposed to receive Measles 1 - Vaccine	487
5	Actual # of women who received LLINs in their Measles 1 - Vaccine	1397
6	Actual # of children who received who received measels 1 - vaccine and an LLIN	1397
7	Total # of LLINs consumed at health facility (source eLMIS)	1704
8	Total # of LLINs distributed through ANC & IVD (source: HMIS/MTUHA)	1614

Number of Facilities Reporting and Not Reporting by Type

S/N	Type	Facilities Reporting			Facilities Not Reporting		
		ANC	Child Health Reporting	eLMIS	ANC	Child Health Reporting	eLMIS
1	Dispensary	100.0 %	100.0 %	0 %	0.0 %	0.0 %	100.0 %
2	Health Centre	100.0 %	100.0 %	0 %	0.0 %	0.0 %	100.0 %
3	Hospital	0 %	0 %	0 %	100.0 %	100.0 %	100.0 %

Reviewed by

Name:----------

Title:----------

Signature:----------

Date:----------

Approved by

Nme:----------

Title:----------

Signature:----------

Date:----------

Jamhuri ya Muungano wa Tanzania
Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto

Usambazaji wa Vyandarua Vyenye Dawa ya muda mrefu Katika Vituo vya Kutolea Huduma za Afya

Mwongozo wa Utekelezaji

USAID FROM THE AMERICAN PEOPLE
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U.S. President's Malaria Initiative
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VECTOR WORKS Scaling Up Vector Control for Malaria Prevention
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