Community Engagement Strategy for Strengthening Routine Immunization in Northern Nigeria

National Emergency Routine Immunization Coordination Center (NERICC)

National Primary Health Care Development Agency (NPHCDA)

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Acronyms

CAN	Christian Association of Nigeria
CBO	Community Based Organization
CBMIS	Community Based Management Information System
CBHMIS	Community Based Health Management Information System
CE	Community Engagement
CEFP	Community Engagement Focal Person
CEWG	Community Engagement Working Group
CHIPS	Community Health Influencer, Promoter and Services
CHW	Community Health Worker
DHIS	District Health Information System
EACH	Emirate Advisory Committee on Health
EPI	Expanded Program on Immunization
FOMWAN	Federation of Muslim Women's Association in Nigeria
GIS	Global Information System
GPEI	Global Polio Eradication Initiative
GRISP	Global Routine Immunization Strategies and Practices
HE	Health Educator
HF	Health Facility
LERICC	LGA Emergency Routine Immunization Coordination Centre
LGA	Local Government Area
LGAF	Local Government Area Facilitator
LQAS	Lots Quality Assurance Sampling
NC	North Central
NE	North East
NERICC	National Emergency Routine Immunization Coordination Centre
NGO	Non – Governmental Organization
NPHCDA	National Primary Health Care Development Agency
NPoPC	National Population and Planning Commission
NTLC	Northern Traditional Leaders Council
NW	North West
NICS	National Immunization Coverage Survey
M&E	Monitoring and Evaluation Officer
MICS	Multiple Indicator Cluster Survey
PHC	Primary Health Care
REW	Reach Every Ward
RI	Routine Immunization
RIFP	Routine Immunization Focal Person
SE	South East
SERICC	State Emergency Routine Immunization Coordination Centre
SW	South West
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
VCM	Volunteer Community Mobilizer
VDCs	Volunteer Development Committees
Vol	Volunteer
VPDs	Vaccine Preventable Diseases
WDC	Ward Development Committee
WHO	World Health Organization

Introduction

Background

Over 40% of under-five mortality in Nigeria is due to vaccine preventable diseases (VPDs)[1]. This is driven in large part by consistently low immunization coverage rates and weak health systems. According to the 2016/17 MICS/NICS survey report, more than 700,000 children were unimmunized and thus vulnerable to VPDs. Contributory to this is the low demand for immunization services and underutilization of PHC services despite demonstrable evidence of vaccine availability and implementation of fixed and outreach sessions, and numerous immunization campaigns. This is because of poor awareness levels, poor access and low health care seeking behavior by community members. 42% of those surveyed in the 2016 NICS/MICS indicated a lack of awareness as a key reason for not being fully immunized. 11% had no faith in immunizations as shown in Figure 1 below.

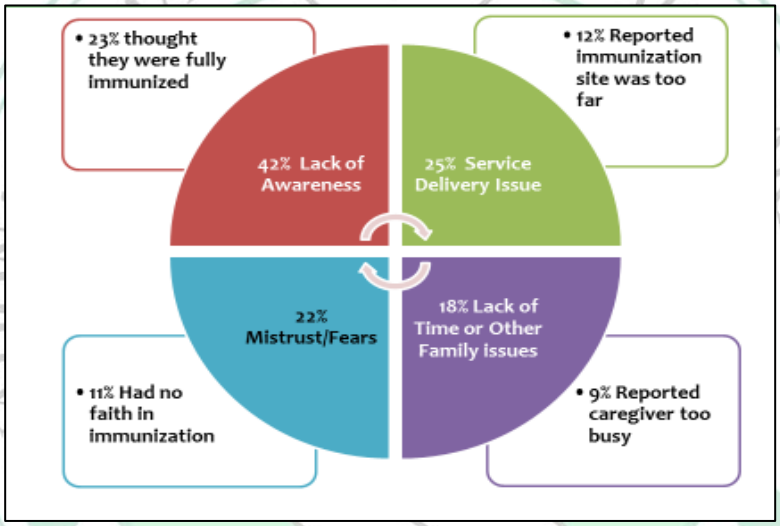


Figure 1: Key reasons why children are not fully immunized

Though a number of supply side factors have been frequently enumerated as contributing factors, weak demand for routine immunization (RI) and poor community linkage for routine immunization are significant demand side constraints. In the MICS/NICS 2016 report, only 33% of children received all three doses of pentavalent vaccine with varied suboptimal coverage rates in all the geopolitical regions. Immunization survey results reveal low coverage, missed opportunities and high numbers of unimmunized occur more in the northern part of the country that in the south. A comparison of 3rd dose pentavalent coverage trends reveals the north west zone as having the lowest immunization coverage (14%), followed by the north east (25%) and the north central (44%), while the southern zones had coverage ranging from 61% to 64% (Figure 2). Not surprising, under-five mortality rates are highest in the North West followed by the North East and North Central zones respectively.

Low immunization coverage rates is also found among the rural poor, the lowest socio economic quintiles and populations with the lowest literacy levels as shown in figure 3.

[1] Estimated numbers of deaths by cause in children younger than 5 years by WHO region and country, 2000- 2010; CHERG

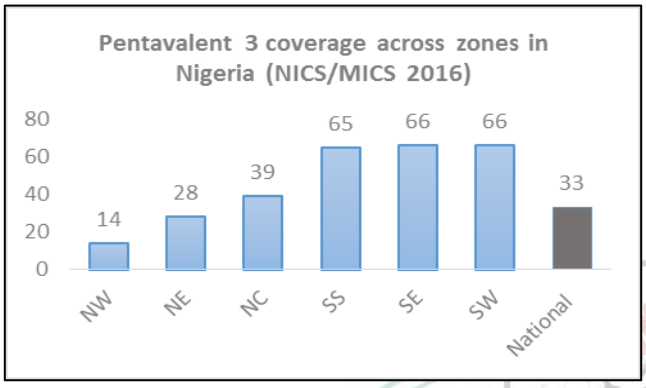


Figure 2: Pentavalent 3 Coverage trends by geopolitical regions (NICS/MICS 2016)

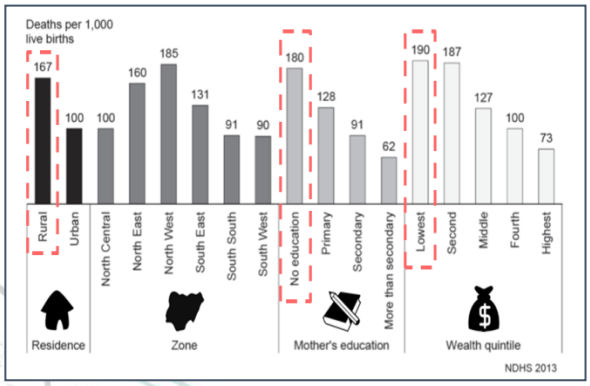


Figure 3: Under-5 mortality in Nigeria by socioeconomic characteristics over ten years (NHDS 2013)

Community related causes of low demand include: Poor community involvement in planning and implementation of RI services, social and cultural barriers to access (lack of knowledge about potential benefits of vaccinations), lack of accountability and a weak governance system for RI, poor service delivery, missed opportunities at health facilities and weak sustainability of planned interventions[2].

The Global Routine Immunization Strategies and Practices (GRISP), 2016 report endorses 'community involvement' and 'strategies to reach' as two of its nine transformative investments in achieving better immunization outcomes. These include:

Strategies to reach: "Investments in tailored strategies that identify under-vaccinated and unvaccinated persons and regularly provide them with the vaccines they need"

and

Community involvement: "Investments in the shared responsibility for immunization delivery between communities and the immunization program to reach uniformly high coverage through high demand and quality services"[3]

Rationale

Community engagement is the process by which the health system works collaboratively with host communities to improve community ownership of health and health programs in accordance with the tenets of Primary Health Care and address both supply and demand-side factors that contribute to poor programme performance and health indices in the community. In immunization, community engagement will help to address both supply and demand-side factors that contribute to under-/non-immunization in order to increase immunization coverage and reach the hardest to reach[4]. This includes communities taking a lead in identifying, owning and resolving issues that contribute to low or stagnating immunization rates.

[2] Nigerian Routine Immunization Strategic Plan, 2013-2015

[3] Global Routine Immunization Strategies and Practices (GRISP): a companion document to the Global Vaccine Action Plan (GVAP). WHO, 2016

[4] Bill and Melinda Gates Foundation: Community engagement to improve routine immunization landscape. 2014

Improving this collaboration with communities requires a well-defined strategy that utilizes the traditional architecture of the community. In Northern Nigeria, this traditional architecture is well known and could be harnessed for coordination and mobilization of communities for action. The Global Polio Eradication Initiative (GPEI) utilized this community architecture in its polio eradication efforts with recorded success; the EPI is utilizing this architecture in the form of Ward Development Committees (WDCs) and Village Development Committees (VDCs), and in the development of micro plans for both routine and supplemental immunization activities. Some northern states have also developed state-specific community engagement strategies which the leadership of the Northern Leaders Traditional Council, the Sultanate and some Emirate Councils are working to harmonize the various components within a coordinated framework.

This strategy therefore builds on these models in providing a definitive and harmonized approach for increasing community participation in routine immunization in Nigeria.

Aim

The aim of this strategy is to engage and sustain community participation and responsiveness to immunization and other PHC services through existing traditional structures in Northern Nigeria.

Strategic Objectives

1. To increase participation of the community in planning for immunizations services as a means of facilitating vaccine uptake and community herd immunity
2. Provide specific support to ensure community ownership of routine immunization (RI) services through traditional structures and leadership in identified high priority states in Northern Nigeria
3. Improve RI performance in low performing LGAs through the conduct of community referrals, defaulter tracking, improving compliance, and reducing missed opportunities for immunization
4. To increase and sustain community demand for routine immunization achieving target coverage of at least 85% by 2019 in identified high priority states and low performing LGAs in Northern Nigeria

Implementation Strategy

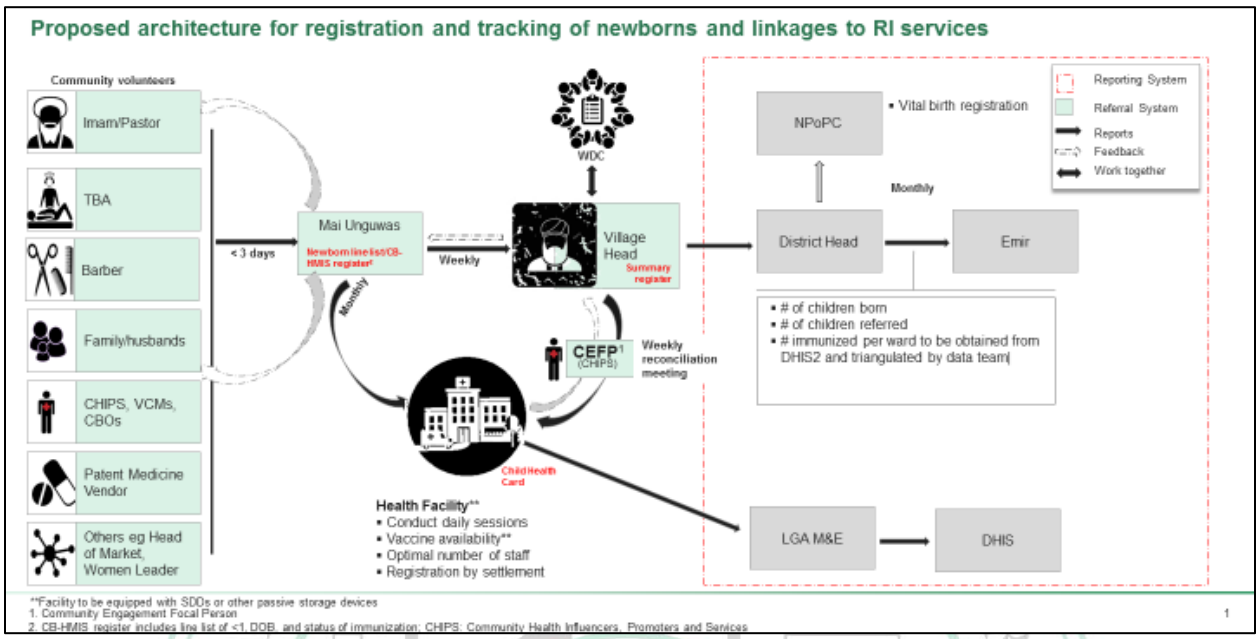


Figure 4: Framework for registration and tracking of newborns and linkages to RI services in Northern Nigeria

Several community landscape analyses have identified key community mobilizers and a hierarchy of leadership within the traditional architecture in the north. Table 1 below identifies some of these stakeholders and the various levels at which they function. Central to this strategy are the key roles played by all stakeholders in facilitating improved outreaches and increased number of children immunized through fixed post sessions.

Table 1: Community engagement stakeholders at respective levels

	Traditional Leadership	Government Leadership for RI	Religious Leaders	Partners and Volunteer Groups
STATE	Emirate Council	SERICC	Muslim Leaders (Chief Imam) FOMWAN Hisbah Church Leaders (CAN)	RI Partners Rotary Club Trade Unions
LGA	District Heads (Hakimi)	LERICC LGA HE	LGA Chief Imam LGA Can Head	UNICEF LGA Coordinator WHO LGAF
WARD	Village Heads	Ward RI Focal Person Ward Development Committee CEFP	Chief Imam CAN	UNICEF Vol Ward Supervisor
COMMUNITY	Community Volunteers TBAs Traditional Barbers CBOs	Health Facility RI Team	Imams Pastors FOMWAN Daawah	UNICEF VCMs Mkt Head (Sarkin kasuwe) Trade Union Heads Women Leader

Tracking newborns

Community volunteers[5] within the course of their daily activities will identify newborn babies, eligible children and defaulters for referral (not later than 3days) to the **Mai Unguwas** for registration using a **newborn line list/ community based management information (CBMIS) register**. The Mai Unguwas are the heads of settlements and communities within the traditional institution. The Mai Unguwas will immediately refer the care giver and child to a designated community health facility for immunization, ensuring that referrals on the **line list/CBMIS register** are transmitted to the **village head** for collation on a **weekly basis**.

On arrival at the health facility, the caregiver/baby is immunized and provided with two slips of a **child health card** containing the child's updated immunization records. A copy is retained by the caregiver whilst the **second copy is returned to the Mai Unguwa** for reconciliation of records. The Mai Unguwa uses this to **mobilize for immunization outreach** and **track defaulters** working with the community volunteers, to resolve any discrepancy between those referred as against those that actually received their immunizations. He follows up with identified defaulting households completing the immunization loop and ensuring referral records are reconciled on a monthly basis with the health facility.

Reconciliation of records

The village head, on receipt of the immunization referral data on a weekly basis from the Mai Unguwas, enters this this record into his **summary register** and liaises with the **health facility** for reconciliation during a **weekly reconciliation meeting.** This weekly reconciliation meeting is anticipated to hold during outreaches or at other designated periods. This meeting is facilitated by a **Community Engagement Focal Person (CEFP)** supports the village head and the health facility to reconcile records sent to the health facility directly by the Mai Unguwas, the facility own records and information from the summary register. This meeting will serve as an avenue to identify and plan for tracking babies who have missed any due vaccines.

The **Community Engagement Focal Person (CEFP)** will be engaged from the **Community Health Influencer, Promoter and Services (CHIPS)** program: a program set up by the National Primary Health Care Development Agency (NPHCDA). It has an overall aim of improving access and providing equitable coverage to essential health services, especially those related to routine immunization and maternal and child survival, by 2020. Ten (10) CHIPS mostly women are to be engaged to work in the community out of which two (men) will serve as community engagement focal persons (CEFP). The CHIPS agents have a mandate to conduct home visits, provide health education and create demand for health services; provide basic first aid treatment, referral to the PHC, data collection and reporting, community surveillance, mobilization for outreaches and special campaigns.

[5] Include traditional birth attendants (ungozomai), traditional barbers (wanzamai), religious leaders such as imams and pastors, patent medicine vendors and heads of families. They also include heads of trade unions such as market women, voluntary community mobilizers and community based organizations

In addition, the Village Head works with the **Ward Development Committees (WDC)**[6] to ensure complete ownership by members of the community of all the primary health care issues.

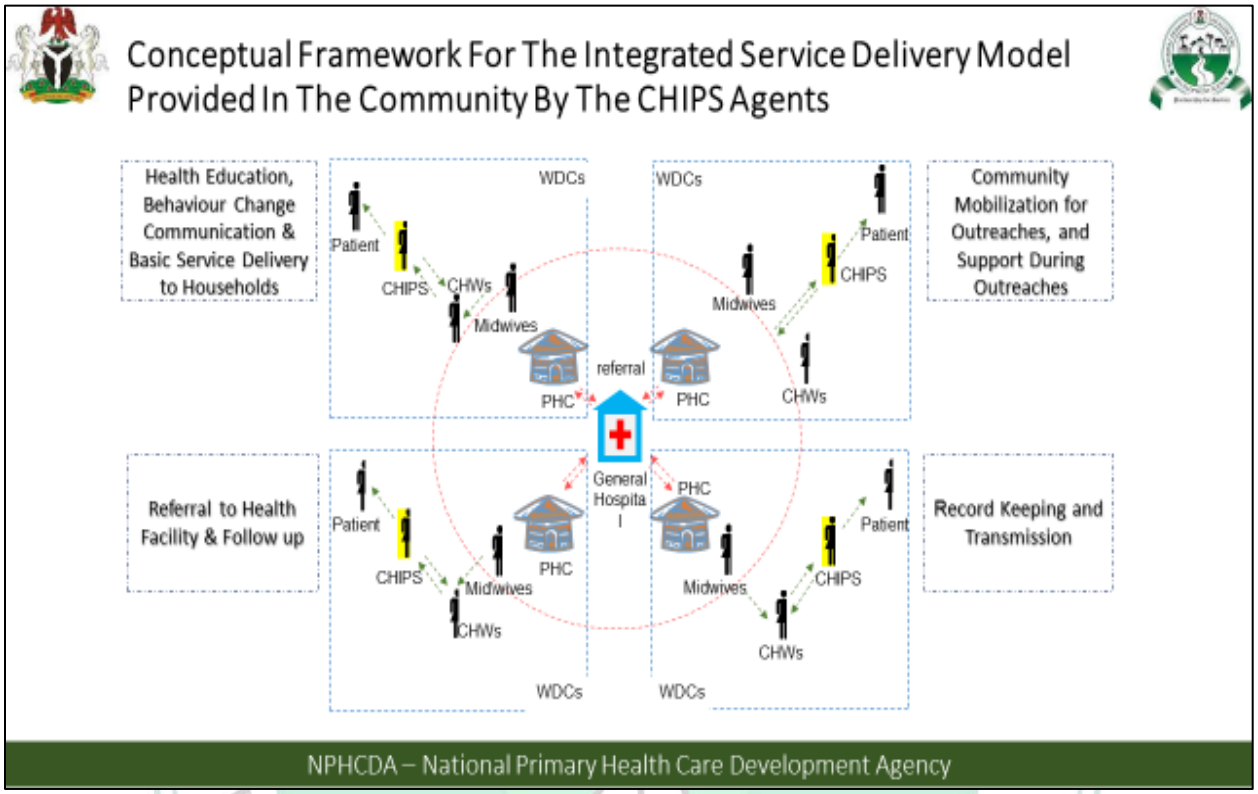


Figure 5: Conceptual Framework for the CHIPS

Data reporting and management

Following this reconciliation meeting, the village head transmits the information to the **district head**, while the health facility transmits the immunization data to the **Local Government Monitoring and Evaluation Officer** for entry into **the District Health Information System (DHIS).** Similarly, the district head on a monthly basis transmits community referral and newborn data received to the Emirate and the **National Population Commission (NPoPC).** Key data reported by the district head includes the number of children born, number of children referred and number of children immunized per ward. The **National Population Council (NPopC)** also receives information on births directly from the health facility where appropriate.

[6] The Ward Development Committee was designed and developed as a social strategy for encouraging community participation and access to primary health care services

Key operating principles

Community participation and ownership

The community shall be at the centre of the community engagement strategy for sustainability and ownership. The concept of community participation depends on the ability of the community to be involved and actively participate in decision making processes (designing, planning and implementation of interventions) related to health in the community. This enables the feeling of ownership and involvement, and will lead to an improvement in the demand for health services and the health system..

Leadership and Governance

Leadership and governance shall be demonstrated at each of the respective levels namely community, ward, LGA and State. Figure 6 below shows the different levels of coordination and responsible persons alongside the feedback loop between the traditional structure and the government health structure.

a. State Level Coordination

At the state level, there shall be established an Emirate Advisory Committee on Health (EACH) which supports the coordination of the implementation of the strategy within the traditional system. The EACH shares referral data, action plans, and key results working with the State Emergency Routine Immunization Coordination Centre to evaluate and plan the implementation of strategies within the traditional system.

b. LGA Level Coordination

The district head supports coordination at the LGA level working with the LGA Emergency Routine Immunization Coordination Centre (LERICC) to review feedback and performance at lower levels, conduct monthly data reviews and use of data for decision making.

c. Ward Level Coordination

Coordination at ward level is domiciled with the village head who works with the WDC and ward community engagement focal person (CEFP) to reconcile referral data with the health facility, review feedbacks, reports, plan and support the tracking of community referrals.

d. Community Level Coordination

The Mai Unguwa supports the design and improved conduct of outreaches working with the health facility to also plan the effective conduct of fixed sessions. He coordinates the registration of newborns, referrals, defaulter tracking and implementation of strategies by community volunteers. He leads the resolution of community issues affecting routine immunization within the traditional system including

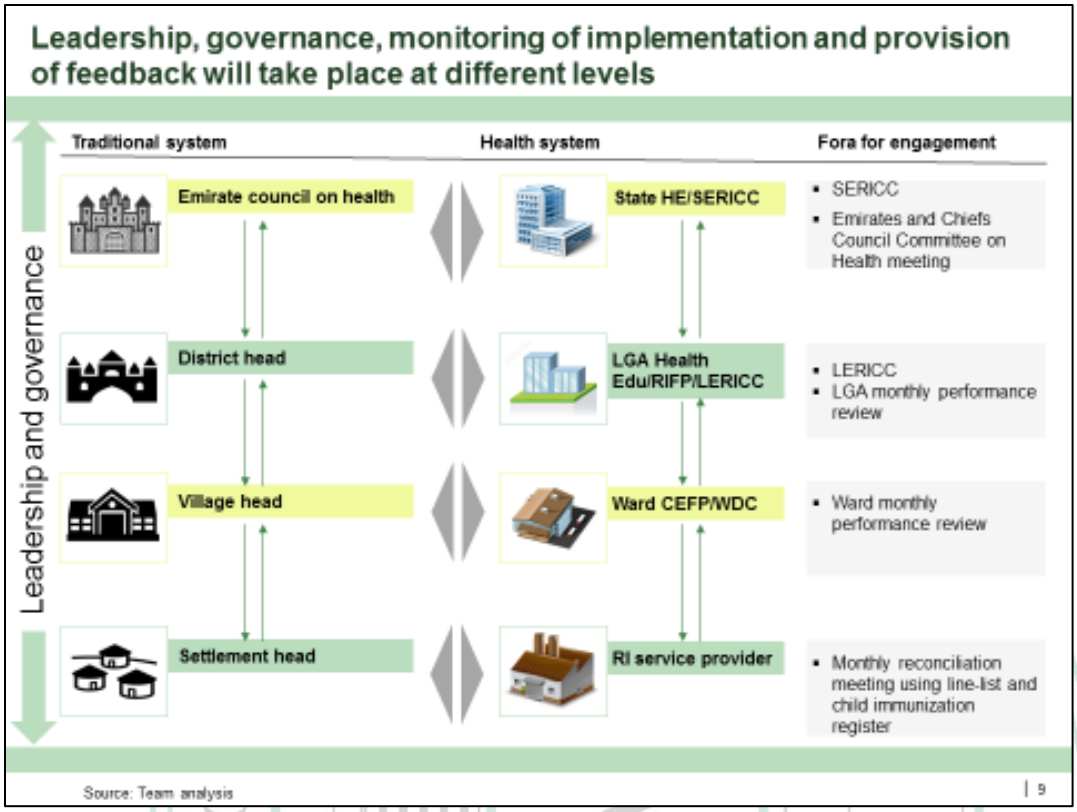


Figure 6: Levels of coordination, leadership and governance

Summarily:

- The community engagement (CE) architecture for RI will use/leverage existing structures e.g. traditional structures
- The CE strategy shall be implemented as non-paid volunteer work.
- The CE strategy will incorporate a name based newborn tracking system which will be managed by traditional leaders/key influencers.
- The CE strategy will also incorporate revised child health cards. Child health cards with a triplicate tear off portion will be provided to health care workers. A copy of the tear off portion will be kept by the HF (to aid defaulter tracking), a copy will be given to the traditional ruler during weekly reconciliation meetings while the child's caregiver will take the card.
- There shall be advocacy to traditional leaders/religious leaders/key influencers to inquire about child health cards during the christening/naming of the newborn baby or upon first contact with the baby. E.g. the Cleric will ask to see the child's card prior to christening/the naming ceremony to ascertain that the child has received the birth vaccination doses. Where this has not happened, the cleric will encourage the child's caregiver to get the child immunized immediately.
- Reconciliation meetings will occur during outreaches. There is also ongoing work to increase the number of outreaches to eligible settlements through an **optimized Reach Every Ward** (REW)

strategy. The strategy involves the triangulation of the GIS data and information from the community (traditional leaders) to determine the actual target and settlements for the implementation of sessions. Joint session planning shall be undertaken by the health facilities and the communities based on the revised session planning approach.

Revised session planning approach:

To achieve the goal of routine immunization coverage of 85% by the end of 2019, it is necessary to implement an optimal number of fixed sessions and outreach sessions to reach un-immunized children in a timely manner. To this end the National Primary Health Care Development Agency recommends the following:

- All children who live within 2Km of a health facility shall be reached via an immunization fixed post
- All children living within 2-5Km from a heath facility shall be reached via an outreach session
- Any child living beyond a 5Km of a health facility that offers Routine Immunization services shall be reached via an integrated mobile session
- All PHC facilities in the urban areas, secondary and tertiary institutions that offer immunization services are expected to conduct fixed daily immunization sessions. Children who are brought to the facility to be immunized must be vaccinated by health care workers. No child should be turned back as a result of not having sufficient babies to utilize a vaccine vial.
- All PHC facilities in rural and semi-urban areas should be conducting at least one fixed session per week unless otherwise advised by the REW microplan
- Immunization outreach services shal be conducted once a week by facilities in the rural areas of the state

Technical approach to setting up and implementing the community engagement strategy

Principal steps in setting up and implementing the community engagement strategy in a State/LGA/Community are outlined below

Conduct Community Diagnosis

1. Identify and select a technical team to guide the development and implementation of the strategy in the state
2. Conduct community diagnosis, stakeholder engagements to identify key community actors and structures available within the catchment population.
3. Review feedbacks and reports received, utilizing same to adapt the implementation of the strategy to a state specific model. For example, a state with more than one emirate council may require the participation of all emirs at the state level EACH

Conduct Stakeholder Engagements

1. Conduct advocacy visits to identified and selected stakeholders

2. Conduct a stakeholder engagement meeting reviewing the strategy with inputs from all members present. Stakeholders may include representatives and key actors from the emirate, state and community influencers including religious stakeholders.
3. Develop, finalize and share with all stakeholders the state specific community engagement strategy

Conduct trainings for all cadre of stakeholders at respective levels

1. Identify training needs for the implementation of the strategy
2. Adapt training materials based on training needs
3. Develop a training methodology
4. Train identified and selected respondents in line with training methodology
5. Conduct supportive supervision and mentoring

Implement the strategy in line with a defined implementation plan

1. Outline an implementation plan. For example, are all LGAs implementing the strategy at the same time or in batches.
2. Emirate council takes full ownership and is directly responsible in implementing the strategy at lower levels
3. Provide support to all levels on identified challenges

Monitor, Evaluate and Re-strategize

1. Monitor the implementation of the strategy, evaluate and re-strategize based on key results

Standard Operating Protocol

Guidelines on roles and responsibilities

State Health Educator

- Coordinate the weekly feedback on the implementation and results achieved on community engagement to the SERICC
- Train, mentor and supervise activities of LGA Community Engagement Focal Persons
- Review the results of the LQAS-RI of all LGAs and the activities of the LGA CEFPs with the EACH
- Track implementation of the strategy at the LGA level and provide update to all stakeholders
- Work with the EACH to implement identified strategies for community engagement in the state

LGA Health Education Officer

- Coordinate the weekly reviews and feedback to LERICC on LGA referral and defaulter tracking conducted
- Train, mentor and supervise activities of Ward CEFPs
- Review results of the LQAS-RI of the LGA and the Ward CEFPs activities with the District Heads
- Track implementation of the strategy at the LGA and provide update to all stakeholders
- Liaise with the District Council including the Scribe to reconcile reports and monitor reporting of data to NPOP-C and the Emirate Council

LGA Routine Immunization Focal Person

The RI Focal person must either be the staff of the State Primary Health Care Development Agencies, State Ministry of Health or Local Government Area and will be responsible for the planning, supervision, data collection and analysis, reporting of routine immunization strategies and services in the catchment health facilities, wards and LGA.

The specific responsibilities for this role include:

- Support the LGA to conduct and supervise immunization fixed and outreach sessions especially in hard-to-reach and missed settlements and provides feedback to the higher levels.
- Work with Ward focal and the LGA M&E officer to collect and analyze data on routine immunization coverage in the wards and LGA.
- To collect data at the ward levels and analyze data for specific trends/patterns of noncompliance, poor coverage, dropouts, vaccine wastage and undertake coordinated action to facilitate the process of reaching such settlements/households to improve immunization coverage.
- Actively participate in identifying, designing, and implementing high-impact interventions to improve routine immunization coverage in the LGA
- Ensure improvements in health facility and ward Routine Immunization focal with knowledge and skill on immunization and vaccine management best practices through supervision and mentorship.
- Support the LGA EPI team in the implementation of emergency RI strategies and in identifying and implementing corrective measures to rectify persistently low coverage settlements and wards.

- To work directly and collaborate with Traditional leaders, existing community structure and Community Health Influencers, Promoters and Services (CHIPS) at the ward level for increased community participation, demand creation and vaccine acceptance to reduce missed children and settlements.
- Participate in the planning and implementation of media and communication activities and work with LGA health educators and community networks to coordinate social mobilization activities in the LGA.
- To coordinate with partners, NGOs, CBOs, Traditional & Religious groups, Women's groups and Youth groups within communities and LGA for their involvement and participation in strengthening routine immunization activities.
- Perform additional activities as requested by the PHC Coordinator and/or State Emergency Routine Immunization Coordination Centre (SERICC).

Ward Community Engagement Focal Person

- Train Facility in-charges and Mai Unguwas on the name-based community engagement strategy
- Facilitate and track the conduct of monthly meetings between Facility I/Cs and Mai Unguwas and the reconciliation of HF child register and Mai Unguwas' line list during the meetings
- Review monthly activities of the Mai Unguwas and health facilities with the Village Head
- Sensitize all Imams on the importance of RI

Routine Immunization Service Provider

- Participate in training of Mai Unguwas on the community engagement strategy
- Maintain updated child register (by birth month & settlements), and add all newborns to the register regardless of vaccination status or whether the child is named yet (e.g. add father/mother's name & compound address/ phone)
- Reconcile Mai Unguwa's line list with child register to identify defaulters and left-outs (newborns never vaccinated) and provide on-the-job mentoring on filling the line list register for Mai Unguwas
- Sensitize all Imams on the importance of RI

Emirate Advisory Committee on Health (EACH)/ Emirate Council Committee on Health (ECCoH)

- Review and track performance of districts using HF linked data from DHIS2
- Actively participate in the CEWG meetings of SERICC
- Review LQAS-RI and use data to take appropriate action
- Provide monthly report on the implementation of the strategy to the Emir and Chiefs

District Head

- Actively participate in monthly RI review and LERICC meetings on community engagement
- Provide implementation update to the EACH
- Supervise all activities of the village heads (both training and implementation)
- Address all unsatisfactory behaviors of the village heads and HWs and flag up to the EACH
- Work with LGA CEFP/HE to plan, monitor and ensure the implementation of strategy
- Ensure RI messaging during Friday prayers

Village Head

- Supervise activities of the Mai Unguwas including their training and involvement in implementation of the strategy
- Review number of linked visits by Mai Unguwas and take appropriate actions based on the data
- Provide update on implementation of name-based CE strategy in the village to the district head
- Report unsatisfactory behavior of the HWs, Mai Unguwas and caregivers to the district head
- Work with ward CEFP to plan and review implementation of the name-based CE strategy

Mai Unguwa

- Enumerate all eligible children in the settlement and maintain an updated line-list thereafter
- Work with RI service provider to plan RI sessions and refer caregivers to HF for vaccination
- Reconcile line list with HF child register together with HF RI service provider each month
- With support from HF, track defaulters and left outs to the HF for vaccination
- Report linked visits to the HF to the village head
- Work with TBAs, barbers, Imams to identify, track and mobilize eligible children back to HF for vaccination
- Report all unsatisfactory behavior of HWs to caregivers or on their duties to the village head
- Seek assistance if unable to read and write

Traditional Birth Attendant (Ungozomai)

- Sensitize mothers on the importance of immunization
- Report all newborns to Mai Unguwa
- Refer all newborns to health facility for vaccination
- Work with Mai Unguwa to track newborns never vaccinated and defaulters

Traditional Barbers

- Sensitize fathers on the importance of immunization
- Report all newborns to Mai Unguwa
- Refer all newborns to health facility for vaccination
- Work with Mai Unguwa to track newborns never vaccinated and defaulters

Religious leaders (Imams/Pastors)

- Conduct sermon on the importance of child health as a responsibility to parents including immunization during naming ceremony of all newborns

Monitoring and Evaluation

Specific indicators have been developed to be tracked within the traditional architecture. These are simple to understand and use for monitoring by the district heads. Other actors such as the Routine Immunization Focal Person (RIFP) and government counterparts are tracked through the LERICC structure.

Indicators to measure performance of referrals in the traditional community engagement structure				
	Indicator	**Data source**	**Responsible Person**	**Frequency**
1	No of children born	*District Head Summary Form*	*District Head*	Monthly
2	No of children referred	*District Head Summary Form*	*District Head*	Monthly
2	No of reports received from village heads	*District Head Summary Form*	*District Head*	Monthly

Financial considerations

The community engagement strategy is to be implemented within communities, LGAs and States on a no – cost basis. Activities implemented by community volunteers are embedded within their normal living and work routines and are primarily on a voluntary basis. Central to this is the demonstration of ownership by community leaders and the traditional leadership to implement this no-cost-strategy as an initiative to improve health outcomes in their communities and areas of jurisdiction.

Possible cost drivers such as data tools have been eliminated with the use of locally sourced exercise books which can be easily procured, ruled and used for reporting across the levels. Other drivers such as meetings have been eliminated by ensuring they occur within the normal work and living cycle of the Community/LGA/State. For example, there already exists a traditional accountability framework where meetings and reports are regularly received from lower levels by the designated leaders in the northern community architecture. This strategy advocates to utilize similar forums to drive its implementation on a no-cost basis.

Sustainability is thus anchored on the ability of the community to own, make decisions and implement a plan towards saving the lives of children in their communities.

Annex

Data Tools (these forms may be ruled into a notebook by the respective user)

District Heads Monthly Summary Form

DISTRICT HEAD'S MONTHLY SUMMARY FORM

STATE: _____ LGA: _____ DISTRICT: _____

REPORT DATE: FROM:_____TO:_____

S/N	DISTRICT	NO OF NEW BORN CHILDREN REPORTED	NO OF NEW BORN CHILDREN REFERRED
TOTAL			
TOTAL NUMBER OF RECONCILIATION MEETINGS HELD WITH HEALTH FACILITY IN THE REPORTING PERIOD:			
CHALLENGES:			

District Head's Name: _____

Sign and Date: _____

Mai Unguwa/Village Heads Weekly Reporting Form

MAI UNGUWA/VILLAGE HEAD WEEKLY SUMMARY FORM

STATE: _____ LGA: _____ DISTRICT: ____SETTLEMENT: _____

REPORT DATE: FROM: _____TO: _____

S/N	NAME	SETTLEMENT	NO OF NEW BORN CHILDREN REPORTED	NO OF NEW BORN CHILDREN REFERRED
TOTAL				

Mai Unguwa/Village Head's Name: _____

Sign and Date: _____

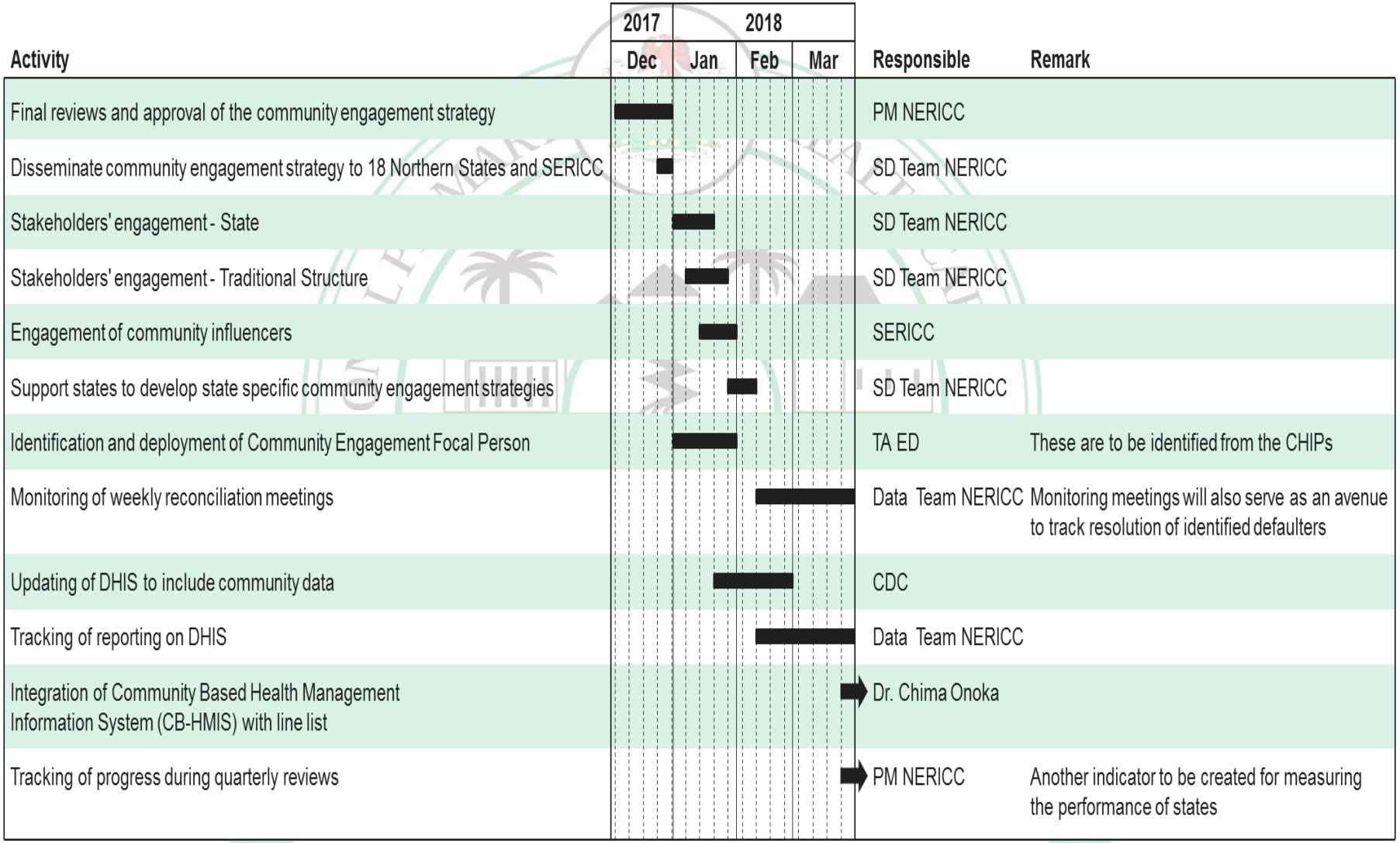
Community Routine Immunization Register

Community Routine Immunization Register

State..... LGA..... Village..... Ward..... Year.....

S/N	Date of Reporting	Name of parent	Phone number	Name of child	Address	Date of Birth			Referred Health facility	Immunization visits				
						Day	Month	Year		1	2	3	4	5

Implementation Plan



Activity	Responsible	Remark
Final reviews and approval of the community engagement strategy	PM NERICC	
Disseminate community engagement strategy to 18 Northern States and SERICC	SD Team NERICC	
Stakeholders' engagement - State	SD Team NERICC	
Stakeholders' engagement - Traditional Structure	SD Team NERICC	
Engagement of community influencers	SERICC	
Support states to develop state specific community engagement strategies	SD Team NERICC	
Identification and deployment of Community Engagement Focal Person	TA ED	These are to be identified from the CHIPs
Monitoring of weekly reconciliation meetings	Data Team NERICC	Monitoring meetings will also serve as an avenue to track resolution of identified defaulters
Updating of DHIS to include community data	CDC	
Tracking of reporting on DHIS	Data Team NERICC	
Integration of Community Based Health Management Information System (CB-HMIS) with line list	Dr. Chima Onoka	
Tracking of progress during quarterly reviews	PM NERICC	Another indicator to be created for measuring the performance of states