



FEDERAL GOVERNMENT OF NIGERIA
FEDERAL MINISTRY OF HEALTH
NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY

COMMUNITY HEALTH INFLUENCERS PROMOTERS AND SERVICES (CHIPS) PROGRAMME

National Implementation Guidelines

February 2022



**COMMUNITY HEALTH INFLUENCERS,
PROMOTERS AND SERVICES (CHIPS) PROGRAMME**

A document of the Federal Government of Nigeria

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TABLE OF CONTENTS

FOREWORD	v
PREFACE	vi
ACKNOWLEDGEMENT	vii
CONTRIBUTORS	viii
ABBREVIATIONS AND ACRONYMS	xi
1.0 INTRODUCTION	2
1.1 Background	2
1.2 Rationale	3
2.0 CONCEPTUALISATION	6
2.1 Concept of the CHIPS Programme	6
2.2 Goal and Objectives	6
2.3 Strategy	7
2.4 Principles of the CHIPS Programme	8
2.5 Strategic Pillars of the CHIPS Programme	9
3.0 THE COMMUNITY HEALTH INFLUENCERS, PROMOTERS AND SERVICES PERSONNEL AND THEIR SCOPE OF WORK	13
3.1 The Scope of the Programme	13
3.2 The CHIPS Personnel	14
3.3 Distribution of CHIPS Agents and CEFPs	14
3.4 Hard-to-Reach Settlements	14
3.5 Incentives and Compensation	15
4.0 GUIDANCE FOR PROGRAMME IMPLEMENTATION AND COORDINATION	17
4.1 Implementation Process	17
4.2 Advocacy Communication and Social Mobilisation	18
4.3 Engagement of Stakeholders Involved in Implementing CHIPS Programme	19
4.4 Selection of the CHIPS Agents and Community Engagement Focal Persons	20
4.5 Harmonisation and Transition of other Community Volunteer Programmes into CHIPS Programme	23
4.6 Female Empowerment	23
4.7 Training	24
4.7.1 Health Component	25
4.7.2 Empowerment Component	27
4.7.3 Research	28
4.8 Programme Management	28
4.8.1 Governance	28
4.8.2 Rewards and Sanctions	30
4.9 Financial Management	31
4.10 CHIPS Commodities Distribution Chain	31
4.11 Supportive Supervision	33

4.12	HMIS Monitoring and Evaluation	35
4.12.1	Recording and Collection of Community Data	36
4.12.2.	Data Reporting	38
4.12.3.	Data Quality Assurance	38
4.12.4.	CHI Programme Indicators	39
4.12.5.	Data Flow	40
4.12.6.	Role of Civil Society Organizations in CHIPS M&E	41
4.12.7	Monitoring and Evaluation of the CHIPS Programme	42
5.0	GOVERNANCE AND COORDINATION	45
5.1	Roles and Responsibilities	45
5.2	Operational Modalities	47
5.3	Specific Roles of Stakeholders	47
5.3.1	Roles of NPHCDA, SPHCDA, LGA and Ward PHC Teams	47
5.3.2	Roles of FMoH, SMoH and Local Government	48
5.3.3	Roles of Donor Agencies and Development Partners	48
5.3.4	Roles of Civil Society Organisations (CSOs)	49
5.3.5	Roles of the Private Sector	49
5.3.6	Roles of the Academia	49
5.3.7	Roles of the State CHIPS Coordinators (SCC)	49
5.3.8	Roles of LGA CHIPS Desk Officer	50
5.3.9	Roles of Ward Development Committees (WDC)	50
5.3.10	Roles of Officers-in-Charge (OIC)	50
5.3.11	Roles of CHEWs or Designated Health Officer	51
5.3.12	Roles of CHIPS Agents	51
5.3.13	Roles of CEFPs	51
5.3.14	Roles of Social empowerment MDAs	52
6.0	RESOURCES NEEDED FOR THE CHIPS PROGRAMME AND FUNDING OPPORTUNITIES	54
6.1	Resource Requirements	54
6.2	Funding opportunities	54
BIBLIOGRAPHY		56
	Appendix I: Detailed Steps for Implementation of the CHIPS Programme	57
	Appendix II: Suggested Areas of Adaption of Programme Guide	58
	Appendix III: Additional Responsibilities for Effective Coordination	59
	Appendix IV: Commodities and Equipment Needed for the CHIPS Programme	60
	Appendix V: Procurement Process for CHIPS Commodities	61
	Appendix VI: Rewards and Sanctions	62
	Appendix VII: Mentoring and Supportive Supervision Levels of the Programme	64
	Appendix VIII: Roles and Responsibilities of NPHCDA and States	65
	Appendix VII: Terms of References for Community Engagement Persons	69

TABLES

Table 1: Targets for Communication Interventions and Issues	18
Table 2: Stakeholders Involvement in CHIPS Programme Implementation	20
Table 3: List of Activities for Harmonisation and Transition Structures into CHIPS Programmes	23
Table 4: Training and Sensitisation of CHIPS Personnel, Supervisors and Stakeholders	27
Table 5: Roles and Responsibilities of Supervisors at Different Levels	34
Table 6: Roles and Responsibilities of FMoH and NPHCDA	46

FIGURES

Figure 1: Conceptual framework for the CHIPS Programme	8
Figure 2: Strategic Pillars and Principles of the CHIPS Programme	10
Figure 3: Scope of Work of the CHIPS Programme	13
Figure 4: CHIPS Programme Implementation Process	17
Figure 5: CHIPS Programme Training Plan	25
Figure 6: Training Cascade for the CHIPS Programme	26
Figure 7: Governance Structure of the CHIPS Programme	29
Figure 8: Components of Financial Management of the CHIPS Programme	31
Figure 9: CHIPS Programme Commodities Supply Chain	32
Figure 10: Monitoring and Evaluation framework of the CHIPS Programme	35
Figure 11: CHIPS Programme: Linking evidence to implementation for improved Community Health Outcomes	36
Figure 12: CHIPS Programme Data Collection Tool	38
Figure 13: CHIPS Programme Data Flow	41

FOREWORD

Nigeria is one of the countries in Sub-Saharan Africa where maternal mortality has remained a public health challenge. The country is also among the top six countries in the world contributing to more than 50% of all global maternal deaths. Progress towards reducing the ratio of maternal deaths has been largely insufficient despite implementation of strategies that promote institutional deliveries, training and deploying new skilled health workers.

Children under the age of 5 years account for 19% of Nigeria's population. More than 75% of deaths in children are due to preventable and treatable conditions. The causes of these include newborn deaths (29%), deaths due to malaria (20%), pneumonia (17%), and diarrhea (19%). Majority of these death are linked to malnutrition and occur at home among the poor, rural and peri-urban populations, where mothers and care givers have limited access to quality, life-saving interventions against the major child-killer conditions.

Nigerian adolescents are vulnerable to a wide range of abuses and harmful, so-called traditional practices, with the largest number of child brides in Africa of about 23 million girls married off as children. Nigeria also has the third highest absolute number of women and girls (19.9 million) who have undergone Female Genital Mutilation and Circumcision (FGM/C) worldwide.

The Federal Ministry of Health is committed to integrated management of these most vulnerable groups, hence, the collaboration with the National Primary Health Care Development Agency to develop the Community Health Influencers Promoters and Services (CHIPS) and Services document, in response to fragmented delivery of healthcare services at community level.

The CHIPS (Programme guide, Training manuals and Data tools) was developed together with partners and stakeholders through widespread consultations at national and sub-national levels. It aligns and builds on existing policies and strategies along the continuum of RMNCAH + N, namely, the revised National Health Policy, the Reproductive Policy, the National Child Health Policy, the Adolescent Policy, the Integrated Reproductive Maternal, Newborn, Child and Adolescent Health plus Nutrition (RMNCAH + N) Strategy, the Integrated Management of Childhood Illness (IMCI) strategy, the National Strategic Plan of Action for Nutrition, and the Integrated Community Case Management (iCCM) of childhood illness among others.

The CHIPS programme is central to achieving Universal Health Coverage and meeting Sustainable Development Goals (SDGs) in Nigeria because it connects the communities to the Primary Health Care System through public enlightenments, awareness creation and support at granular level. I hereby call on all relevant Federal Ministries, Department and Agencies, State Governments, State Ministries of Health and their Agencies, partners, Civil Society groups, Donors, the Private Sector and other stakeholders to support the Federal Ministry of Health and NPHCDA in the implementation of the CHIPS programme.



Dr. Emmanuel Osagie Ehanire. MD, FWACS
Honourable Minister of Health

PREFACE

The World Health Organization has recommended that national governments should provide leadership in the development of community-based programme. This call is informed by the increasing global recognition that the attainment of universal health coverage is not feasible without investment in strengthening the community component of PHC. More recently, at the regional level, the West Africa Health Organization called on member states to harmonize their investments for community-based primary health care and strengthen their planning and implementation of CBHW training programmes and service provision.

The Community Health Influencers Promoters and Services (CHIPS) Programme was borne out of a need to accelerate progress towards achieving universal health coverage in Nigeria. The goal is to contribute to the reduction of maternal and child morbidity and mortality by creating demand for and equitably increasing access to essential primary healthcare services.

The programme seeks to harmonize all existing community-based health worker programmes which have been characterized by fragmentation and verticalization, thus yielding suboptimal outcomes. These aspirations are in line with the goal of the National Policy and Strategic Framework for Community Health which is to provide clear guidance for integrated and sustainable delivery of healthcare to communities in Nigeria.

Integrated Childhood Case Management (iCCM) is a global strategy that seeks to expand access to treatment of leading childhood killer diseases - malaria, pneumonia, and diarrhea especially in hard-to-reach areas where children under five lack access to health facilities.

The goals of the two programmes are similar, and in alignment with the harmonization mandate of the CHIPS Programme, the FMOH and NPHCDA have led the harmonization of the iCCM and CHIPS Programmes which will serve as the beginning of many more collaborations with stakeholders to strengthen delivery of primary healthcare at the community level.

The revised National Guidelines for CHIPS Programme Implementation is an output of the harmonization process and represents the strategic direction the country has taken with regards community-based health worker programmes, it outlines guidance for programme implementation, roles and responsibilities of different stakeholders and resources required at country level



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The development of Community Health Influencer, Promoters and Services (CHIPS) Programme in Nigeria is one of the key outcomes of a well-coordinated collaborative effort put in place by the Federal Ministry of Health and the National Primary Healthcare Development Agency to mitigate duplication of efforts in implementation of health interventions across the continuum of care at the community level.

The Community Health Influencer, Promoters and Services documents (Programme Guide, Training Manuals, Job Aid and Data tools), were developed through a multi-stakeholder effort; hence, outputs of the process captured the views and aspirations of Government and stakeholders working with the sole aim of improving health indices in Nigeria.

The Federal Ministry of Health and the National Primary Healthcare Development Agency with full cognizance of the patriotic zeal, in depth understanding and commitment displayed during the development process of the CHIPS document are obliged to appreciate stakeholders individually and collectively.

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ACSM	Advocacy Communication and Social Mobilisation
BHCPF	Basic Health Care Provision Fund
BoI	Bank of Industry
BPP	Bureau of Public Procurement
CBN	Central Bank of Nigeria
CBOs	Community Based Organizations
CHEWs	Community Health Extension Workers
CHIPS	Community Health Influencers Promoters and Services
CORPs	Community Oriented Resource Persons
COVID-19	Coronavirus Disease 2019
CSOs	Civil Society Organisations
DBN	Development Bank of Nigeria
DHIS2	District Health Information System 2
DSNO	Disease Surveillance & Notification Officer
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
FME	Federal Ministry of Education
FMWA	Federal Ministry of Women Affairs
FP	Family Planning
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information and Communications Technology
ITF	Industrial Trust Fund
ISS	Integrated Supportive Supervision
LGA	Local Government Area
LGHMT	Local Government Health Authority Management Team
LLIN	Long Lasting Insecticidal Net
LMCU	Logistics Management Coordinating Unit
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
M&E	Monitoring and Evaluation
MNCH	Maternal New-born and Child Health
MoU	Memorandum of Understanding
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organisation
NICS	National Immunisation Coverage Survey
NPHCDA	National Primary Health Care Development Agency
NURTW	National Union of Road Transport Workers
NSCIP	National Supply Chain Integration Programme
NSCS	National Strategic Cold Store
OIC	Officer -in -Charge
ORS	Oral Rehydration Solution
PMG MAN	Pharmaceutical Manufacturers Group of Manufacturers Association of Nigeria
PHC	Primary Health Care

PHCrSCC	Primary Health Care Revitalisation Supply Chain Committee
PLA	Participatory Learning and Action
PNC	Postnatal Care
PIU	Programme Implementation Unit
RDT	Rapid Diagnostic Test
RMNCAEH + N	Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SMEDAN	Small and Medium Enterprises Development Agency of Nigeria
SMoH	State Ministry of Health
SOP	Standard Operating Procedure
SPHCDA	State Primary Health Care Development Agency
TBA	Traditional Birth Attendant
ToT	Training of Trainers
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
VCM	Volunteer Community Mobiliser
VHW	Village Health Worker
WDC	Ward Development Committee
WHS	Ward Health System
WFP	Ward Focal Person
ZTO	Zonal Technical Officer

01

INTRODUCTION

1.0 INTRODUCTION

1.1 Background

The health status of women and children in Nigeria ranks amongst the poorest in the world. Every year, 33,000 women die from pregnancy-related causes while 1,000,000 children die from mainly malaria, diarrhoea,¹ and pneumonia, with malnutrition contributing up to 50% of all child deaths.² Nigeria has the second largest number of stunted children in the world, with over 13 million children under-five affected.² These deaths represent 14% and 11% of the global annual maternal and child deaths respectively. The high maternal and child mortality is largely due to poor coverage with high impact interventions for example, skilled attendance at delivery is 43%,³ while PENTA3 coverage is 50% with the proportion of children fully immunized at 31%.⁴ Such sub-optimal health outcomes constitute a considerable impediment to achieving global targets for improved maternal and child survival.

Given the poor health coverage indicators, Nigeria is unlikely to progress towards Universal Health Coverage (UHC) unless equitable access to effective primary health care (PHC) services is achieved and coverage significantly increased. Despite some gains in improving the PHC delivery system in Nigeria, poor and rural communities as well as other socially disadvantaged groups have disproportionately poorer access to health care services, accounting for higher burden of diseases and deaths compared to their wealthier and urban counterparts.

Primary Health Care is the cornerstone of Nigeria's health policy central to the attainment of UHC and Sustainable Development Goal 3. Consequently, the country has made significant investments in the revitalization of PHC through the Ward Health System (WHS). The system seeks to ensure a functional PHC facility in each ward, where an essential package of primary health care services is delivered. While recognizing the place of these reforms in removing supply side constraints by improving access to and quality of services provided at PHC facility level, demand for services remain suboptimal to underserved rural and poor populations.

In these underserved communities, demand and utilization of PHC services remain low because of persistent systemic weakness, poverty, ignorance, mistrust, misconceptions, poor perception of quality of care and cultural preferences for traditional care amidst other factors. Alternatively, private health facilities are expensive making them economically inaccessible to poor households. This results in vulnerable underserved populations resorting to sub-optimal care from informal private healthcare service providers including patent medicine vendors and traditional healers.

It is increasingly being recognized that attainment of UHC is not feasible without investment in the community component of primary health care that seeks to expand access to underserved populations and works towards raising awareness, as well as stimulating demand for PHC services.

¹Prof C.O. Onyebuchi Chukwu. Maternal, Newborn and Child Health in Nigeria: where are We Now? A Presentation by Honourable Minister of Health, Nigeria. Available online at https://www.who.int/pmnch/about/steering_committee/B11_11_02_nigeriapresentation.pdf. Last accessed 22/10/2021

²Global Nutrition Report 2021

³2018 Nigeria Demographic and Health Survey (NDHS), National Population Commission

⁴2016 National Immunisation Coverage Survey (NICS), National Primary Health Care Development Agency

At conception of the Basic Health Services Scheme, the precursor of PHC in Nigeria, a new group of health professionals were introduced for PHC services provision at both health facility and community levels. One of these was the Community Health Extension Workers (CHEWS), who were expected to spend between 60% - 80% of their time in the community, providing community based PHC services at household and community level. Unfortunately, health worker maldistribution, attrition and shortages have meant that most community health workers remain in facilities for service delivery. These challenges are further compounded by poor remuneration and funding of outreach services, thus contributing significantly to poor mobilisation and delivery of community-based interventions.

The National Primary Health Care Development Agency (NPHCDA) is addressing the supply side challenges through the revitalization of PHC initiative. However, for significant improvement in coverage and attainment of health-related Sustainable Development Goals (SDGs), further expansion of basic health services to community level and addressing barriers to use of health services through effective community level strategies must be undertaken. The Community Health, Influencers, Promoters and Services Programme aims to address low and inequitable uptake of PHC services at the grassroots level.

1.2 Rationale

To improve critical health outcomes in Nigeria, high-impact interventions are required to bring PHC services closer to households in communities. While supply-side improvements are essential, community-level interventions are necessary to further expand access to basic services, restore citizens' confidence in the PHC system and improve demand for health services. Currently, there is the need to integrate PHC services at the facility and community levels and to provide harmonised community mobilisation platforms as a strategy from Polio transition programme to broader sustenance of health system and improved integrated community outreach services. Individuals who reside and operate within their communities as health influencers hold immense promise for stimulating and sustaining positive health behaviours including informed demand for health care services. Such individuals will serve as front-line informants and health influencers to enhance the awareness about health problems, availability of care, timely access to care, prompt referral and the overall demand for health care.

In the 1980s, the Village Health Worker (VHW) concept was introduced as an approach to improve community-level health service delivery. Similar interventions in several low to middle-income countries have demonstrated the potential for such programmes to improve access, equity, and coverage of PHC interventions including immunisation, maternal and other PHC services.^{5,6} While Nigeria identified the VHW Programme as bearing great promise, several other programmes have emerged, including the Community Oriented Resources Persons (CORPs), Voluntary Community Mobilisers (VCMs) and Community Focal Persons in support of various other interventions.

The multiplicity of VHW-style programmes, driven by various stakeholders has led to considerable verticalisation of community health structures, poor coordination, inefficiencies, and concerns about value for money. It is noteworthy that many of these programmes are similar in context and concept, yet they are not comprehensively linked in a way that enables programmes to leverage

⁵Health Extension Worker (HEW) Programme in Ethiopia (2004)

⁶Sustaining Health: The Roles of BRAC's Community Health Volunteers in Bangladesh, Afghanistan and Uganda (https://ndc.gov.bd/lib_mgmt/webroot/earticle/2029/Community_Health_Volunteers_in_BD.pdf)

these existing structures to implement critical interventions for the attainment of one common goal. As part of its mandate to coordinate the development of the PHC systems in Nigeria, with oversight function of the Federal Ministry of Health, the NPHCDA has continued to explore mechanisms to address challenges inherent in the VHW model for Nigeria, and to scale-up the programme from the various models that have been developed over the years.

While carrying out interventions to improve the supply of PHC services, it is important that community-level health personnel focus on ensuring that households in need of such services are informed and motivated enough to demand as well as use these services at all levels. While noting that the intervention needs to be planned and implemented nationally, it should also be locally contextualised, driven, and connected to community level accountability structures as well as the local and national health systems. It is on this basis that the NPHCDA is guiding the implementation of the Community Health Influencers, Promoters and Services (CHIPS) Programme.

02

CONCEPTUALISATION

2.0 CONCEPTUALISATION

2.1 Concept of the CHIPS Programme

The Community Health Influencers, Promoters and Services (CHIPS) Programme, established by the NPHCDA and endorsed by the Federal Government of Nigeria, is designed to improve on the Village Health Worker (VHW) concept. The VHW programme was introduced as part of the PHC approach in Nigeria in the mid-1980s where community volunteers selected by their communities were trained to provide basic curative care for common childhood illnesses, health education and counselling in health. The CHIPS Programme is structured to stimulate and support households in communities to seek and obtain PHC services through various delivery platforms, namely: the facility, outreaches and home services using volunteer CHIPS personnel. To ensure sustainability of the programme, which is primarily based on volunteerism, strategies have been put in place to economically empower the CHIPS Agents to secure a means of livelihood.

The steps leading to the critical improvement of the VHW concept that is characterised by the CHIPS Programme are as follows:

1. Harmonise existing community-level service structures that have similar scope with the VHW concept into an improved, better focused and coordinated approach.
2. Develop and deploy an integrated training programme for the harmonised community-based health workers
3. Promote efficiency by sharing the harmonised database of community-level human resource for health across all tiers of government development and implementing partners as well as other relevant stakeholders.
4. Link the personnel in a very explicit way to existing and new interventions and programmes that are being implemented to achieve rapid improvements in health outcomes in Nigeria.
5. Integrate the personnel into the overall PHC system and to the community and traditional accountability mechanisms.
6. Ensure sustainability of the CHIPS strategy and the integration of improvements into the nation-wide PHC system as well as into the National and State Strategic Health Plans for Primary Health Care.
7. Promote the improved Nigerian Village Health Worker model, transitioning to CHIPS that focuses on the responsibilities of influencing and promoting health, collecting basic community-level information and providing basic services.
8. Leverage the opportunity provided by the programme to promote female empowerment, job creation and overall economic and social improvement, as a sustainability strategy, especially as the CHIPS personnel are working as volunteers.

2.2 Goal and Objectives

The overall goal of the CHIPS Programme is to contribute to reduction of maternal and child morbidity and mortality by improving access to and equitably increasing coverage of basic primary health care services, especially those relating to maternal and child health, including improved access to treatment for common childhood illnesses.

The specific objectives are to:

1. Equitably increase access to basic PHC services in Nigeria especially at the community level
2. Increase demand for PHC services by individuals and households
3. Foster community participation and ownership of the programme
4. Promote female empowerment and socio-economic development
5. Promote public-private partnership in primary health care development, especially at community level.

2.3 Strategy

The strategy is to transition all current community-based workers from programmes that are phasing out, such as VCMs of the polio eradication initiative and harmonize all other community-based programmes (for example CORPs), into a single national programme. Both the training programmes and health workers will be integrated, so that there is one training programme, one curriculum and one category of community-based workers – the CHIPS Personnel, made up of CHIPS Agents and Community Engagement Focal Persons. A minimum of 10 CHIPS Agents, preferably females will be trained in each political ward. They will be responsible for working at household level, to provide counselling, create demand and refer household members to PHC facilities for uptake of needed services. In addition, they will provide basic preventive services, case management of fever, cough, and diarrhoea in children under -five years and first aid services. These will lead to an expansion of access to services, bringing health care as close as possible to where people live and work, and increase uptake of PHC services at the community and PHC facility levels. Two Community Engagement Focal Persons (CEFPs) per ward preferably males, will be recruited and trained to support the work of CHIPS Agents. Their roles include fostering male participation in health care, promoting community engagement and participation through strategic participatory community communication interventions (community dialogues, town hall meetings, community workshops, etc) targeting key stakeholders.

Critical to the success of the Programme is ensuring the availability of a functional PHC facility that will serve as the site for referral in the ward. This PHC facility serves as the anchor point for CHIPS management, supervision, and data collation. It also serves as an operational logistics hub for the distribution of commodities, which CHIPS Agents need for service delivery and to stimulate demand for services at the health facility.

Conceptual Framework for the Integrated Services Delivery Model Provided in the Community by the CHIPS Agents

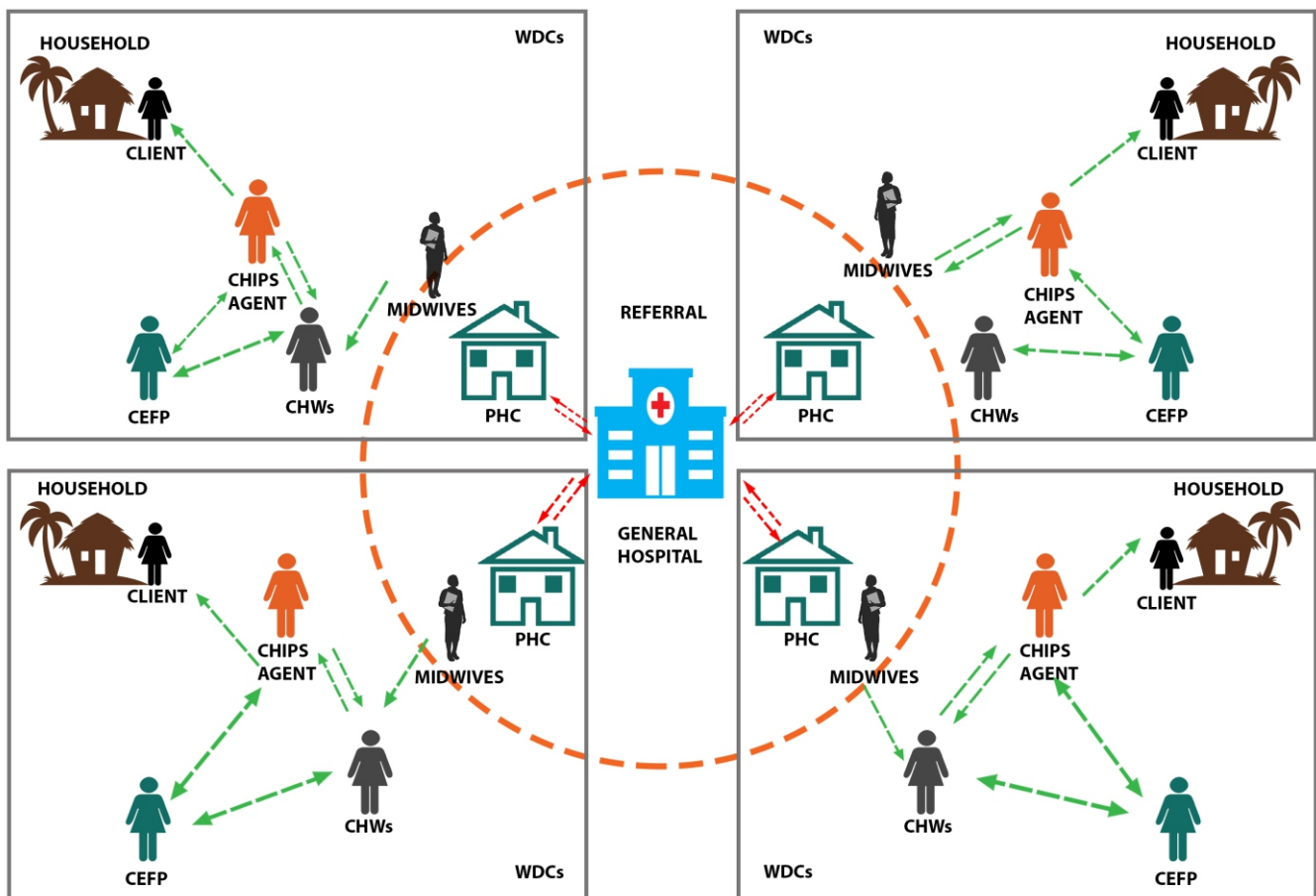


Figure 1: Conceptual framework for the CHIPS Programme

Figure 1 shows the framework for the health component of the CHIPS programme. It is envisaged that the Programme will increase access to health care, improve the continuum of care, link households to the healthcare systems, complement national data systems, improve health outcomes, and strengthen the health system. Importantly, the programme will drive improvements in maternal, neonatal, and child health services, including routine immunisation. In so doing, the programme will complement the efforts of the Federal Government to ensure functional PHC facilities across the country. This will help to redress inequity in access to health care services by the poor, rural populations and other socially excluded groups, thus accelerating progress towards UHC.

2.4 Principles of the CHIPS Programme

The implementation of the CHIPS Programme in Nigeria shall be guided by the following key principles:

1. **Ownership:** NPHCDA will provide effective leadership in the development of the CHIPS Programme strategy and plans through a broad consultative process involving key stakeholders. States will provide similar leadership at state level in adapting the programme to their local context and developing state implementation plans. NPHCDA and states will take the lead in coordinating partner resource support for community-level PHC interventions at national and state levels respectively.

2. Alignment and harmonisation: Partners will align their support including funding for all community level PHC interventions and activities at all levels with the CHIPS Programme plans to be developed at national and state levels. To this end, their community-based programmes and plans will be integrated and synchronised, including their community-level health workers to optimise the efficiency and effectiveness of service delivery at that level.
3. Transitioning: Community-based health workers of various Programmes coming to an end, like the Volunteer Community Mobilisers (VCMs) will be transitioned into CHIPS personnel (CHIPS Agents or Community Engagement Focal Persons). All other community-based health workers being supported by other Programmes that go by various nomenclatures will be harmonized and known as CHIPS personnel.
4. Volunteerism: Engagement of personnel for the CHIPS Programme, i.e. the CHIPS Agents and Community Engagement Focal Persons (CEFPs) is strictly on volunteer basis. Therefore, no monetary allowance in the form of salary will be offered. However, allowances for logistics, communication and other programme related costs will be paid. The amount will be at the discretion of implementing states with other non-monetary incentives built into the programme.
5. Accountability and transparency: The principles of good governance, openness and responsiveness will be integrated into the CHIPS programme at all levels. The people and institutions saddled with responsibility will strive to serve citizens in an honest, trustworthy and transparent manner and be accountable for the performance of the CHIPS programme.
6. Partnership and collaboration: The process of implementing the Programme will be consultative and participatory, involving all key stakeholders in the public and private sector including beneficiaries and decision-makers at all levels. Effective stakeholder consultation and management will be undertaken all through the Programme development and implementation processes as these are critical to achieving the desired results.
7. Ethics and respect for Human Rights: The providers and consumers of health care services will be treated with courtesy, dignity, impartiality, and respect.
8. Equity and Gender Sensitivity: Fairness, equity and justice will be watchwords mainstreamed into the entire CHIPS Programme roll out. In addition, planned interventions and activities will address the health needs of women, children, and other disadvantaged and socially excluded groups. Specific interventions will focus on female empowerment as a key strategy to redress gender inequity.
9. Community engagement and participation: Individuals, families and communities are at the heart of the CHIPS Programme. Their interests and felt needs should be given priority when making decisions. Individuals and communities will be enabled to participate in decision-making in the planning and implementation of interventions to improve their health and well-being through proactive engagements using participatory approaches.
10. Innovation: This will form the basis for successful implementation of the CHIPS Programme where commitment to continuous service improvements through creativity and approaches that work will be promoted.

2.5 Strategic Pillars of the CHIPS Programme

The strategic pillars of the CHIPS programme focus on health interventions to be carried out by the CHIPS personnel and female empowerment strategies for the CHIPS agent.

1. Health Interventions

a. Demand Generation

The key work of the CHIPS personnel will be to generate demand for health interventions, using various interpersonal communication strategies at household and community levels. They will also link these communities to primary health care services at the revitalized ward focal primary health

care facility where the full compliment of PHC services and health workers will be available to provide the needed services. Additionally, they will promote community participation and mobilise communities for health actions.

b. Health Services Provision

The main component of the health services to be provided by the CHIPS personnel will be health promotion and disease prevention. Through strategic behaviour change communication, they will engage households and communities on ways of promoting their health, especially that of women and children and how to prevent common infectious diseases. The curative services they will provide is treatment for common childhood illnesses within the framework of Integrated Community Case Management of Childhood Illnesses. They will also provide first aid as well as identify and refer other sick people in the households.

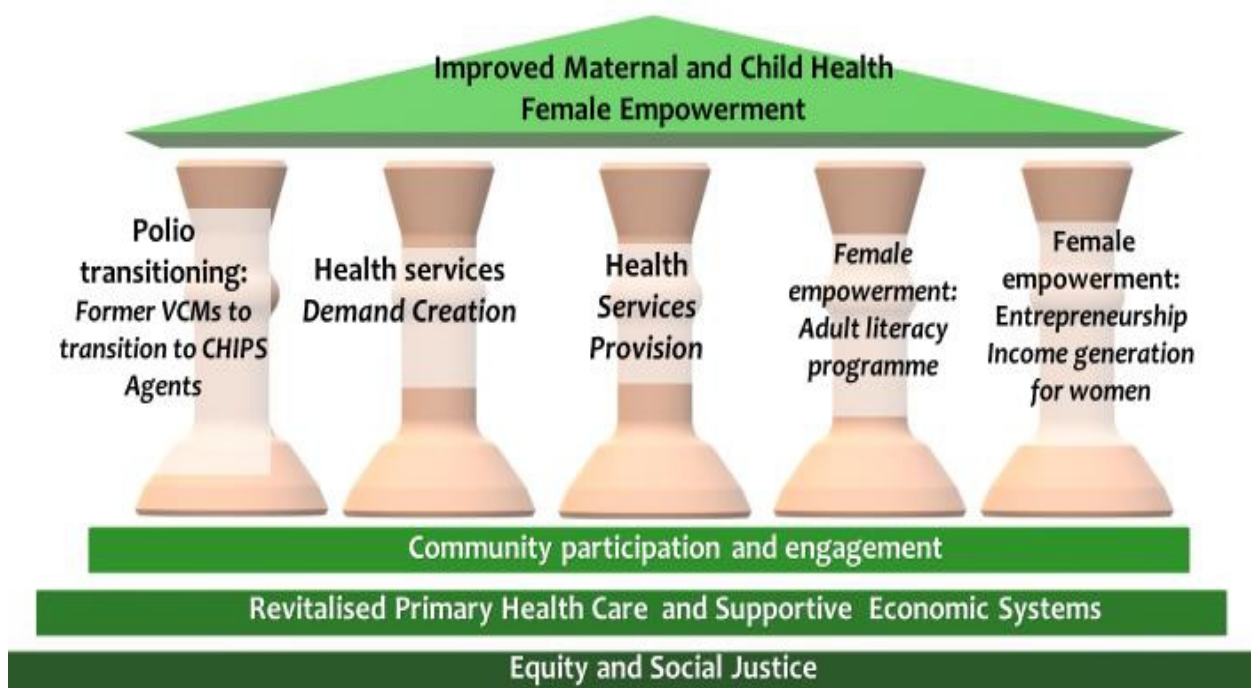


Figure 2: Strategic Pillars and Principles of the CHIPS Programme

2. Female Empowerment

Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. It is a major contributor to socio-economic development. In the context of the CHIPS Programme, the focus is on empowerment of the CHIPS Agents who are mostly females as a sustainability strategy. This is because the core work is based on the principle of volunteerism and the majority of the women come from a low socio-economic background without a viable means of livelihood and some, not quite literate. NPHCDA will work with the relevant agencies and the private sector to develop this component, which will comprise:

a. Entrepreneurship and Income generation skills acquisition

To ensure sustainability of the programme, which is primarily based on volunteerism, strategies have been set up to empower the CHIPS Agents economically. They will receive training in

entrepreneurship and income generation, following which they will be supported to form cooperatives and provided seed grants or linked to credit facilities. This component will ensure the CHIPS Agents have a means of livelihood as they are volunteers, thus empowering them economically and contributing to the socio-economic development of their communities.

b. Adult Literacy

Mechanisms for linking CHIPS Agents with literacy gaps to adult literacy programme are being established to enhance their performance on the job. The Programme also offers opportunity for career development and advancement for motivated CHIPS Agents.

03

THE COMMUNITY HEALTH INFLUENCERS, PROMOTERS AND SERVICES PERSONNEL AND THEIR SCOPE OF WORK

THE COMMUNITY HEALTH INFLUENCERS, PROMOTERS AND SERVICES PERSONNEL AND THEIR SCOPE OF WORK

3.1 The Scope of the Programme

The CHIPS Programme provides the appropriate framework to primarily focus health education and services in households within communities, link communities to health services and facilitate their uptake of integrated PHC services. The scope of work delineates the responsibilities of the CHIPS personnel at household and community level as described in Figure 2 below:

Scope of Work

Community Mapping	<p>At beginning of the work conduct:</p> <ul style="list-style-type: none"> Community mapping, household numbering and collection of basic demographic information on all members of households in her defined practice area for identification of target groups
Demand Creation for Health Services	<p>During home visits:</p> <ul style="list-style-type: none"> Educate pregnant women on importance of ANC, birth preparedness and complication readiness, health facility delivery and track ANC visits Identify pregnant women not attending ANC and encourage them to attend Use the 1000 days checklist to identify relevant services a pregnant woman and a child aged 0-2 years requires and advise appropriately. Also track immunization defaulters and counsel appropriately Monitor uptake of immunization. Encourage household members on how to utilize other PHC services
Health Education and Counselling	<p>During home visits and community engagements, health educate and counsel on:</p> <ul style="list-style-type: none"> Basic preventive care Child health and services including immunization and nutrition Maternal & Newborn Health and Services (ANC/Delivery/PNC/Nutrition) Community Water, Sanitation and Hygiene (WASH) Reproductive, Sexual and Adolescent Health HIV/AIDS, TB, Hepatitis, Non Communicable Diseases
Provide Support and Treatment Services	<p>During home visits provide Maternal and Newborn care and support services and manage the sick child:</p> <ul style="list-style-type: none"> Identify danger signs in pregnancy and newborn and refer Support mothers in developing a birth preparedness plan Provide essential newborn care Provide disease specific treatment for children under-five for cough, fever and diarrhea and identify danger signs and refer Identify and refer children with Severe Acute Malnutrition Provide basic first aid and refer for advanced care
Facilitate Referral and follow-up	<p>During home visits follow-up and refer:</p> <ul style="list-style-type: none"> Pregnant women for ANC, facility delivery, PNC, FP services Children under-five for immunization and other services Others as indicated above
Disease Surveillance (Observation, Reporting & Monitoring)	<p>During home visits identify:</p> <ul style="list-style-type: none"> Diseases of public health importance including epidemic prone diseases Births and deaths
Community Level Data Collection and Reporting	<p>During home visits:</p> <ul style="list-style-type: none"> Record and report activities during every encounter with household members

Figure 3: Scope of work of the CHIPS Programme

3.2 The CHIPS Personnel

The unit for implementation of the CHIPS Programme is the ward level. The number of CHIPS Agents and the CEFPs will depend on the size of the ward and population density. However, given the average population per ward, it is recommended that the minimum number of CHIPS Agents and CEFPs per ward should be 10 and 2 respectively. These CHIPS Personnel will work on volunteer basis.

1. CHIPS Agents:

The CHIPS Agent will work in 200 – 300 assigned households, depending on population density, family type, and geographical distribution, to provide individual and household level health care services.

2. Community Engagement Focal Person (CEFP):

The CEFP works primarily at community level fostering male participation, mobilizing and promoting community participation and addressing barriers to demand for services.

3.3 Distribution of CHIPS Agents and CEFPs

A minimum of 10 CHIPS Agents and two (2) CEFPs are expected to be recruited per ward. The exact number of CHIPS Agents per ward and the number of households assigned to each Agent in their assigned catchment areas may vary. Below are the factors that will affect the variability:

1. For highly populated communities, the number of CHIPS Agents may be more than the minimum required to cater for the increased number of households in such areas.
2. The spatial distribution of households across a geographic area and the time it takes to move between them determines how CHIPS Agents are assigned across catchment areas.
3. Hard-to-reach communities are prioritised for deployment of CHIPS Agents to address gaps in access to health care. More CHIPS agents should be assigned to such areas.
4. The prevalence and incidence of health conditions of interest affect their functional distribution. For example, more personnel are required in areas with large gaps in the provision of routine immunisation or seasonal variations of malaria prevalence.
5. The ratio of CHIPS Agents to catchment areas should be adjusted on an ongoing basis using information and performance data gathered through a formal feedback mechanism.
6. Special measures should be put in place for personnel working in security-compromised areas, such as the engagement of local vigilante groups, government security agents or other measures agreed upon in consultation with traditional institutions.

3.4 Hard-to-Reach Settlements

Hard-to-Reach (HTR) settlements are often cut off from other communities around them by difficult terrain caused by mountains, forests, deserts, rivers and a host of other natural barriers making the movement of persons, goods and services difficult. Communities that are far from a health facility could also be considered as Hard-to-Reach as the client may find it difficult to access the facility.

3.4.1. Criteria for labelling a settlement as Hard-to-Reach

- a. Presence of geographical barriers like rivers, creeks, lakes, mountains, forest, and others making health facilities inaccessible to settlements.
- b. Settlements situated in areas of insecurity, wars or communal clashes which interrupt the normal flow of health system processes.

- c. The settlements are at least 5km or more than 40minutes' walk from:
 - i. The nearest functional health facility
 - ii. Any constructed road tarred or un-tarred

3.4.2. CHIPS implementation in HTR settlements (Bridging the gaps)

For effective implementation of the CHIPS programme in HTR settlements, the following should be considered:

- a. CHIPS Agents should be resident within the HTR community
- b. The number of CHIPS Agents in HTR settlements will be determined by using the formula: one CHIPS Agents to 100 – 150 households or depending on the geographical context of those settlements
- c. There may be need to provide extra quantities of commodities to CHIPS Agents in HTR settlements to prevent stock-out however they should be monitored to prevent pilfering.
- d. The Community Engagement Focal Persons (CEFPs) will work with the HTR settlements' heads to establish means of ensuring that anyone referred by the CHIPS Agents gets to the referred facility. Arrangements should be made to facilitate transportation of referred clients especially in HTR areas.
- e. The focal PHC facility covering the HTR settlement should arrange outreaches to these communities to complement the activities of the CHIPS Agents and provide them support. The outreach services will also serve as a forum for replenishment of CHIPS commodities and data submission, mentoring and supportive supervision
- f. Considerations maybe made to increase the stipends for these CHIPS Agents.

3.5 Incentives and Compensation

A strategic principle of the CHIPS Programme is volunteerism. CHIPS Agents have an influential role in their community. This will give them a sense of satisfaction and purpose as they will make a positive impact on the lives of their community members. Female empowerment as a strategic pillar of the Programme is aimed at improving the socio-economic status of the CHIPS Agents. They will be engaged in income generating activities as an incentive to the invaluable role they play in their communities.

High performing CHIPS personnel with interest in academic improvement will be encouraged to progress to become CHEWs, Nurses or Midwives upon meeting the criteria for admission into schools of Health Technology, Nursing and Midwifery. States should liaise with authorities in these institutions to facilitate the process with support from NPHCDA.

04

**GUIDANCE FOR
PROGRAMME
IMPLEMENTATION AND
COORDINATION**

4.0 GUIDANCE FOR PROGRAMME IMPLEMENTATION AND COORDINATION

The CHIPS implementation framework is adapted from similar community-based programmes such as the Integrated Community Case Management (ICCM) of childhood illnesses, Village Health Worker (VHW) programme and the Volunteer Community Mobilisers (VCMs) programme. The implementation process, stakeholders involved and their specific roles are described below:

4.1 Implementation Process

The CHIPS Programme implementation will be carried out at the National, State, Local Government, Ward and Community levels. The implementation process includes three phases (Figure 4) while the detailed implementation steps are as shown in Appendix I.

1. **Pre-implementation:** activities planned towards implementation of the programme include the engagement and sensitization of stakeholders at all levels, securing buy-in and commitment to the programme, resource mobilisation baseline assessment, development of work-plans, procurement of CHIPS commodities, establishment of a commodity supply chain management system for CHIPS commodities, printing of training materials and programme launch.
2. **Implementation:** includes selection training and deployment of CHIPS personnel, selection and training of supervising CHEWs and WDCs, mapping of communities as well as assigning settlements/households to CHIPS Agents. Other implementation activities include, service provision by the Agents and CEFPs, mentoring and supervision by CHEWs, replenishment of commodities, literacy training, empowering the Agents with skills to engage in small and medium scale ventures and oversight by WDCs/traditional institutions. Furthermore, operational/implementation research will be carried out to improve programme performance.
3. **Monitoring and Evaluation:** involves systematic collection, collation and analysis of data of the CHIPS Programme to improve programme implementation. This phase includes periodic supportive supervision, based on existing guidelines for data quality assessment. Periodic evaluation of the programme will also be carried out

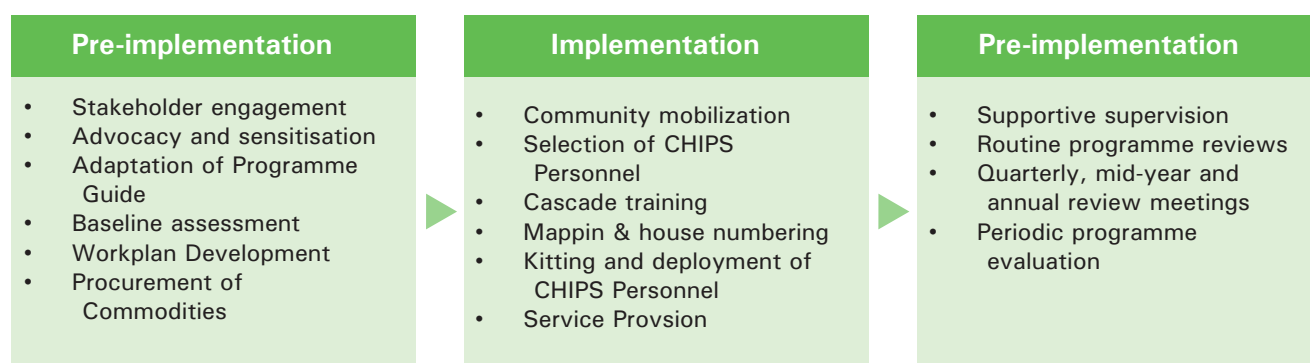


Figure 4: CHIPS Programme Implementation Process

Details on Programme Implementation are shown in Appendix 1 while Appendix 2 suggests areas for CHIPS Programme adaptation.

4.2 Advocacy Communication and Social Mobilisation

NPHCDA will develop a communication strategy that seeks to provide guidance for the achievement of the desired social and behaviour change needed at all levels, by different stakeholders for the success of the programme. This will be informed by a situation analysis that provides the needed information on key communication issues in the areas of advocacy, sensitisation and behaviour change communication. The communication strategy will detail the key issues from the situation analysis, target segmentation, communication objectives and approaches to achieving the communication objectives, messages and the channels of communication. The communication strategy will be adapted at state and local levels to fit local contexts.

The suggested targets and key issues to address in the strategy are shown in Table 1.

Table 1: Targets for Communication Interventions and Issues to Address

Communication intervention	Targets	Purpose
Advocacy and sensitisation	Political leaders and policy makers at all levels	<ul style="list-style-type: none"> Awareness creation Buy-in and creation of an enabling environment for programme success, including enactment of relevant policies and provision of funds
	MDAs at national and state levels; LGA leadership	<ul style="list-style-type: none"> Awareness creation Buy-in and alignment of their programmes with CHIPS Support implementation
	Development partners	<ul style="list-style-type: none"> Buy-in Alignment of their support to national and state plans Resource and technical support for implementation
	Traditional and community leaders	<ul style="list-style-type: none"> Awareness creation Buy-in and support for programme implementation
Social mobilisation	Community-based organisations, Ward Development Committees	<ul style="list-style-type: none"> Awareness creation Buy-in Support in monitoring programme implementation
Sensitisation and behaviour change communication	Ward development committees, communities and primary target beneficiaries (household and community members)	<ul style="list-style-type: none"> Awareness creation Acceptance of programme and CHIPS personnel Uptake of services Positive behaviour change
	Health care providers	<ul style="list-style-type: none"> Awareness Support programme implementation Ensure quality service provision and acceptance of referrals

Suggested Advocacy, Communication, and Social, Mobilisation (ACSM) related activities at different stages of the programme implementation include:

1. Pre-implementation phase

- a. Development/adaptation of costed communication strategy
- b. Advocacy to policy makers and governors at national and state levels for buy-in, policy and funding
- c. Stakeholders' sensitization meetings at national/state and local levels
- d. Development and dissemination of IEC materials
- e. Engagement and sensitization at LGA, ward and community levels include the following activities:
 - i. LGA sensitization meetings/workshops
 - ii. Health worker sensitization meetings
 - iii. Community dialogues/ participatory learning and action (PLAs) with WDC and community members
 - iv. Announcements in places of worship and use of town announcers
- f. Media engagement

2. Implementation phase

- a. Continue implementation of communication strategy
- b. Continue advocacy
- c. Distribution of IEC materials
- d. Interpersonal communication and counselling at community level
- e. Media programmes
- f. Specific interventions as need arises

4.3 Engagement of Stakeholders Involved in Implementing CHIPS Programme

To ensure effective implementation and coordination at different levels, stakeholders have been grouped to describe the roles and levels of operation, as they support the FMoH, NPHCDA and SPHCDA's (See Table 2).

Table 2: Stakeholder Involvement in CHIPS Programme Implementation

Level	Team description	Composition	Support/Oversight
National	National Team	FMoH/NPHCDA	FMoH, FMoWA, FME, other MDAs, Development Partners, NGOs, Private Sector, Academia, Professional Associations, Financial Institutions, Traditional Institutions, Religious Leaders, National Council of Women Society of Nigeria, Civil Society Organisations (CSOs), International Finance Corporation (World Bank Group)
Zone	Zonal PHC Team	NPHCDA, SPHCDA	Development Partners, NGOs, Private Sector, Traditional Institutions, , Religious Leaders, National Council of Women Society of Nigeria, CSOs
State	State PHC Team	SPHCDA, NPHCDA State Team Leads	SMoH, SMoWASD, SME, other MDAs, Development Partners, CSOs, Professional Associations, Academic Institutions, Financial Institutions, NGOs and the private sector, Traditional Institutions, Religious Leaders, National Council of Women Societies of Nigeria, Youth Council, Faith-Based Organisations
LGA	LGA PHC Team	Local Government Health Authority Management Team (LGHMT), NPHCDA ZTOs, SPHCDA	Community-Based Organisations, Traditional Institutions, NURTW, NGOs, Faith-Based Organisations, Religious Leaders, National Council of Women Society of Nigeria, Market Women Association, CSOs
Ward	Ward PHC Team	Officers – n-Charge (OIC) of PHC facility CHEWs Ward Focal Person CHIPS Agents	Ward Development Committees, Traditional Institutions, NURTW, Community Based Organisations, Religious Leaders, Market Women Association, CSOs, Youth Group, Faith-Based Organisations

4.4 Selection of the CHIPS Agents and Community Engagement Focal Persons

The CHIPS Programme recognises that resources have been invested in training and engagement of volunteers of existing community-based Programmes. Therefore, selection of CHIPS personnel will prioritise volunteers of these programmes such as CORPS of the ICCM Programme, VCMs of the Polio Eradication Initiative (PEI), Village Health Workers (VHWs), etc. Where such existing volunteers do not meet the set criteria for selection or do not meet the required number, other members of the community nominated as potential influencers by the community will be considered. Furthermore, by harmonising and transitioning existing volunteers, duplication of efforts will be minimised and resources will be maximised.

The selection of CHIPS Agents and CEFPs is a collaborative process that is primarily community driven with guidance and support from the LGHMT, recognised local civil society groups, SPHCDA, NPHCDA and development partners. The community mechanisms that are involved include the communities, Ward Development Committees (WDCs), the PHC facility managers and existing traditional institutions.

4.4.1. Criteria for Selection of CHIPS Agents

To ensure community ownership, integration and achievement of Programme goal and objectives, the selection of CHIPS Agents (at a meeting to be held at the ward level) will be based on the following recommended criteria (See Appendix VIII for eligibility assessment checklist):

Candidates should be:

- a. Preferably 18 to 65 years of age
- b. Respected within their communities
- c. Preferably married (indicating a likelihood to remain in the same community) and/or should be influential members of the communities
- d. Preferably be female; however, in some situations, men can be recruited where there are no females, or where there is a strong case to use one
- e. Able to read and write in English and/or the local language, preferably having a minimum qualification of primary school leaving certificate
- f. Willing to be engaged for at least two years for the sustainability of the programme
- g. Nominated by the community or traditional institutions/WDCs or the local structure that has community-wide representation and acceptance, where the former does not exist. This should be preceded by widespread sensitization
- h. Candidates should be members of and residents in the communities or wards and cannot be transferred to or from another ward
- i. Able to communicate effectively in the local language and have a sound understanding of the norms and cultural values of the community
- j. Of good social standing and character in the community

Additional considerations based on prevailing contextual factors:

- k. Existing CORPs, CBHVs, VCMs, Polio vaccinators, VHWs and retired health workers who are nominated should be given preference during selection, after assessment of their performance in their previous roles and having met eligibility criteria.
- l. While considering the recommended persons for the programme, attention should be given to additional individual capabilities such as aptitude, attitude, motivation, communication skills, integrity, leadership qualities and the ability to reach out to community members.
- m. The CHIPS Programme shall also leverage existing or future social safety net programmes of the Government of Nigeria for personnel engagement.

In cases where there are otherwise qualified women who do not meet literacy or educational requirements for the CHIPS Programme, arrangements shall be made in collaboration with the Federal Ministry of Education to link such candidates to flexible adult literacy education programmes to improve their capacity for reading and writing, to enhance performance and ensure proper data collection.

4.4.2. Criteria for Selection of Community Engagement Focal Persons

Candidates should be

- a. Preferably male
- b. Preferably 25 years of age or above
- c. Preferably married, indicating a likelihood to remain in the community

- d. Educated with a minimum qualification of secondary school leaving certificate
- e. Willing to be engaged for at least two years
- f. Nominated by the community or traditional institutions/WDCs or the local structure that has community-wide representation and acceptance, where the former does not exist this should be preceded by widespread sensitisation
- g. Members of and resident in the communities/wards following training, they should not be transferred to/from another ward
- h. Able to communicate effectively in the local language and have a sound understanding of the norms and cultural values of the community
- i. Of good social standing and character in the community

BOX 1 Selection of CHIPS personnel [CHIPS Agents and Community Engagement Focal Persons (CEFPs)]:

The selection of CHIPS Agents/CEFPs should be conducted in collaboration with the focal ward PHC, the existing traditional institutions and the Ward Development Committees (WDCs) where they exist. The pre-selection meeting to be held at the ward level should involve the following:

- National/State Facilitators:
 - National Team
 - Zonal PHC Team (ZTO)
 - State PHC Team

LGA/Ward level Facilitators:

- LGA Health Management Team (LGHMT)
- Traditional Leaders in each ward/Ward PHC Team
- Officer-in-charge of the PHC facility
- WDC members
- Other staff of the PHC facility (Nurse/Midwife, Community Health Extension Workers (CHEWs), Medical Records Officer, Pharmacy Technician and Lab Technician). During the meeting, the following should be discussed:
 - Goal, objectives, and concept of the CHIPS Programme.
 - Criteria for selecting the CHIPS Agents and CEFPs.
 - Roles and responsibilities of the CHIPS Agents and CEFPs.
 - Roles of the facility staff in providing oversight of the CHIPS Agents and CEFPs.

Subsequently, the nominated candidates should be screened using an eligibility criteria checklist.

Post selection, a meeting would be held to discuss the results of the screening and the most eligible candidates selected, ensuring representation of all communities in the ward. Reports would be written and shared with the PHC team at LGA, state and national level

4.5. Harmonisation and Transition of Other Community Volunteer Programmes into CHIPS Programme

NPHCDA in collaboration with relevant Stakeholders will provide coordinated support to SPHCDA for harmonisation and transition of all existing community-level service structures that have a similar scope of work with the village health worker concept into the CHIPS Programme to:

1. minimise duplication of efforts
2. reduce inefficiencies and wastages
3. enhance integration
4. strengthen effectiveness and delivery of results.

Table 3: List of Activities for Harmonisation and Transition of Community Structures into CHIPS Programme

S/N	Activity
1	Engagement of Stakeholders
2	Establishment of a government-led coordination structure to agree on planning timelines and oversee transition (steering committee)
3	Establishment of task teams specific to focal States to work with SPHCDA to coordinate state-level harmonisation activities with Stakeholders
4	Conduct mapping of all community-based services and workforce by location and partners' support.
5	Conduct a gap analysis to determine gap between the training the volunteers had received and the CHIPS curriculum and determine how to structure the CHIPS training to fill the gaps
6	Conduct a strategic workshop to review mapping and identify strategic options for transition
7	Development of a costed strategy for the most feasible transfer option including maintenance, transfer and phase out of VCMs/CORPs/CBHV/CVs into CHIPS Programme
8	Development of the final transition plan, agreed among partners including funding commitments and implementation roadmap
9	Review of Programme documents (TOR inclusive) for VCMs, CORPs, CBHVs, CVs
10	Harmonise CHIPS and other (VCMs/CORPs/CBHV/CVs etc.) Programme documents
11	Train other Programme Agents (VCMs/CORPs/CBHV/CVs, etc.) as CHIPS Agents (to be done in phases as states implement)
12	Assess performance of VCMs/CORPs/CBHV/CVs within the scope of work of CHIPS Agents

4.6. Female Empowerment

NPHCDA, working in collaboration with the Federal Ministry of Women Affairs, Federal Ministry of Education, Small and Medium Enterprise Development Agency of Nigeria (SMEDAN) and other Stakeholders will develop the national female empowerment strategy which will be adapted and implemented in the states under the guidance of the relevant MDAs.

a. Adult Literacy:

The programme will work closely with Adult Literacy and Mass Education Department of the Ministry of Education at the national and state levels to infuse adult literacy into CHIPS Programme. Potential CHIPS Agents that cannot read and write in English will be linked to adult literacy classes in the state.

b. Entrepreneurship and Income Generation:

Guidance for this component of the Programme will be provided by the Federal Ministry of Women Affairs, SMEDAN, Bank of Industry (BoI), Central Bank of Nigeria (CBN) and others. The key implementation steps will comprise:

- i. Rapid assessment to identify income-generating skills, interests and opportunities amongst the CHIPS Agents in a given locality. These will be linked with existing opportunities in the state.
- ii. Selection of Income generating skills: In each state/locality four (4) income generating skills will be identified for the training. The criteria for selection of the skills will be based on;
 - The interest of the CHIPS Agent
 - Existing opportunities in the locality (e.g. States' vision and priority, training and funding opportunities)
 - Marketability (e.g. Opportunities to market products, the feasibility of selling the products)
 - Cost and duration of training
 - The balance between performing CHIPS functions and engagement in the income generating activity
- iii. Conduct of Training: The CHIPS Agents will be trained in income generation skills and also they will be trained in financial management, record keeping and how to form and run a cooperative society.
- iv. Support to the CHIPS Personnel trained to form and register a cooperative
- v. Support the trained CHIPS Personnel with grants/seed money or linked them to where they can access loans
- vi. Monitor the performance of the CHIPS Agents in income generating activities they have been trained on

4.7 Training

A well-coordinated training strategy is necessary to ensure CHIPS personnel acquire the necessary competency to perform their work effectively, in addition to equipping them with the right skills to have a means of livelihood. The training has two (2) components;

1. Health component
2. Female Empowerment component

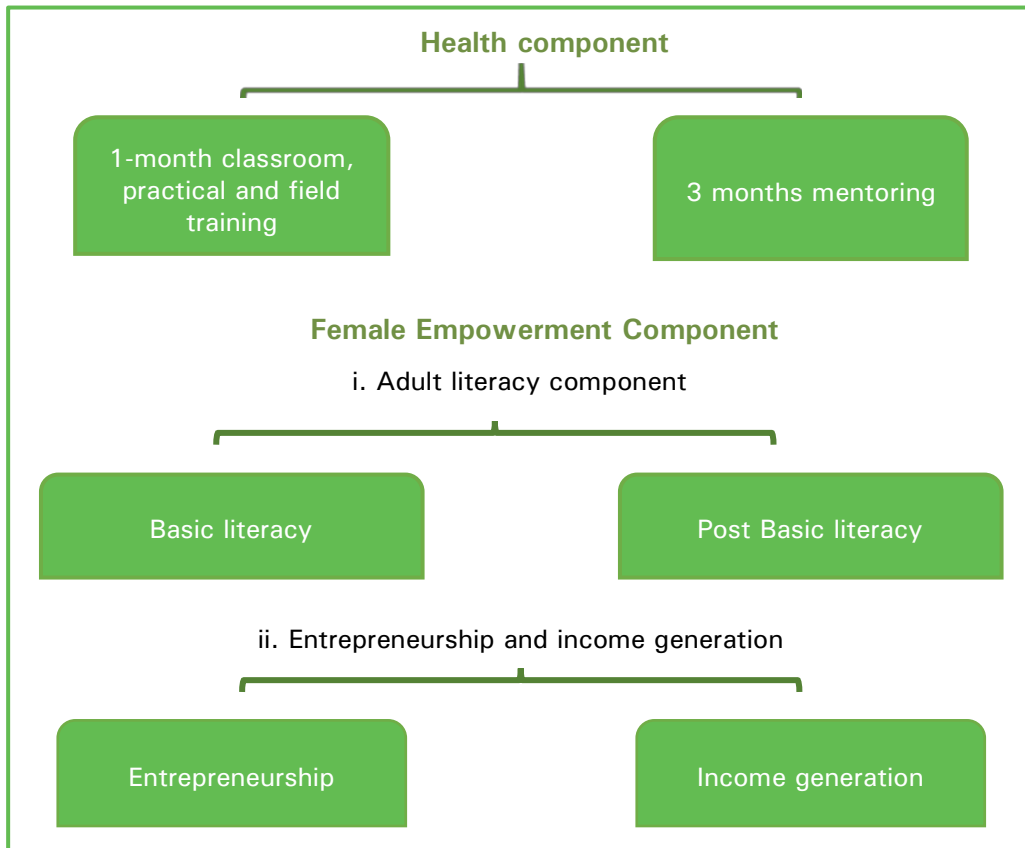


Figure 5: CHIPS Programme Training Plan

4.7.1. Health component

A training manual based on current evidence for planned community-based interventions was developed. It has modules consisting of several sessions with learning objectives meant to equip the CHIPS personnel and their supervisors with required knowledge and skills.

The Modules for CHIPS Agents training comprise:

- Module 1: Introduction to the training and the CHIPS Agents in the context of primary health care
- Module 2: Knowing your community
- Module 3: CHIPS personnel as agents of behaviour change
- Module 4: Introduction to conducting Home Visits and Data Tools
- Module 5: Care of the pregnant woman and new-born
- Module 6: Management of the sick child
- Module 7: Promoting child health and nutrition
- Module 8: Promoting the health of the adolescents
- Module 9: First aid
- Module 10: Promoting family and community health
- Module 11: Role of CHIPS Agents in home visits, community linkages, referral and data systems

The Manual for Training of Supervisors and CEFPS comprise the following Modules

- Module 1: Community-based Communication for health
- Module 2: Demand generation
- Module 3: Mentoring
- Module 4: Supportive Supervision
- Module 5: Data management

The training materials that have been developed for the CHIPS Programme training include the following:

- i. Facilitators' training manual for the CHIPS Agents
- ii. Facilitators' training manual for the supervisors Job Aid for CHIPS Agents
- iii. Training flipbooks (volumes 1 – 3)

The CHIPS personnel training will be in phases for the health component. The training shall comprise an initial two-week class-based session, a one-week field component and a one-week review session. These sessions will enable them to understand their roles and provide general guidance to help them commence their work. The next phase of learning is a structured mentoring session for three months to be anchored by the supervising CHEWs (or designated health worker in the absence of a CHEW) to reinforce and deepen their knowledge of various modules taught during the classroom sessions. A mentoring guide has been developed for use during the period. The supervising CHEW is expected to make at least 12 contacts with each CHIPS Agent during the period, paying greater attention to weaker CHIPS Agents and areas where they have knowledge or skill gaps.

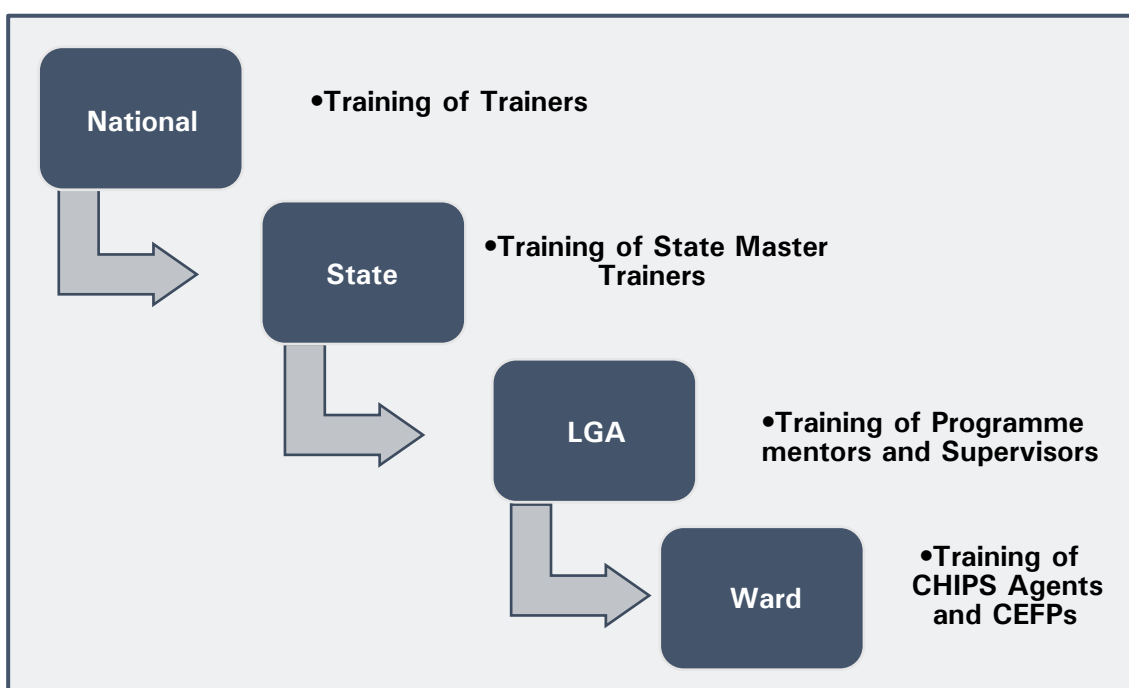


Figure 6: Training cascade for the CHIPS Programme

The training process will be decentralised with direct oversight by NPHCDA, SPHCDA and partners for quality control. The CHIPS personnel will be trained by the State facilitators and health workers at the PHC facilities supported by national master trainers to ensure quality control. To ease CHIPS Agents' ability to understand the content of the training manual and carry out their responsibilities, the training approach will include participatory methods: adult learning techniques (pictorials, videos communication tools, storytelling, role plays, experience sharing and the constant repetition of key messages and use of similes). Evaluation tools (pre- and post-tests, evaluation forms) would be used to assess both the participants' understanding of subject matter and facilitators' delivery of subject matter.

There will also be a refresher training based on gaps identified during supportive Supervision and monthly review meetings. Needs-based in-service review and training sessions will help ensure continuous performance improvement and update on protocols for health services.

Table 4: Training and Sensitization of CHIPS Personnel, Supervisors and Stakeholders

S/N	Targets for training	Scope of training	Duration
1	CHIPS Agents	Building their competency for mapping, collection of basic demographic information, counselling and service delivery	4 months - One month for training on the complete curriculum or 2 weeks if training RMNCAEH + N focussed - 3 months structured mentoring
2	CEFPs	Building their competency on community mobilization, demand creation, addressing barriers to uptake of services, promoting male participation in uptake of health services	4 weeks (participating in training of CHIPS Agents) and two days training on demand generation
3	WDCs/ NURTW / Traditional institution	Sensitization on their roles in the CHIPS programme	1 day
4	CBOs / CSOs	Build their capacity in programme monitoring at community level	1 day
5	OIC / CHEWs	Build their capacity to carry out their roles effectively	3 days on Supportive supervision and mentoring 12 days on CHIPS programme
6	LGA level	Sensitization on CHIPS programme	1 day
7	State level	Sensitization on CHIPS programme	1 day
8	State team	Build a pool of state trainers	12 days
9	National stakeholders	CHIPS programme sensitization	2 days
10	National team	Build a pool of national master trainers	12 days

4.7.2. Empowerment Component

CHIPS Agents who have literacy gaps would receive Adult literacy education for a specified duration depending on their literacy status so they can function effectively (read and write in English). This will be in collaboration with the Mass and Adult literacy division of the Federal Ministry of Education. Strategies have been set up to empower the CHIPS Agents by equipping them with entrepreneurial skills that would enable them to engage in income-generating activities. Training schedule would be developed for each skill acquisition programme and trainers identified. Training would be in collaboration with the Ministry of Women Affairs, Small and Medium Scale Enterprises of Nigeria (SMEDAN), Bank of Industry (BoI) and the Central Bank of Nigeria (CBN). Table 4 shows the training activities needed to activate the programme in each State.

4.7.3 Research

The CHIPS Programme is a new approach to integrated community level health care delivery in the country that aims to improve the health of community members within the context of community and female empowerment. This is because the Programme recognizes that health status and related health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental (social, economic and physical) and policy. The ecological model will be used to study the influences of these factors on health and how they change with implementation of the Programme.

Using various designs and methods, the following concepts and their relationships will be explored in the research:

- a. Influence of socioeconomic and demographic factors on health outcomes
- b. Gender roles in promoting community health
- c. Influence of community mobilisation on health-seeking behaviour
- d. Economic evaluation of a community-centred demand generation programme
- e. Regional differences in implementing a centrally-coordinated health intervention and their impact on programme results
- f. Effectiveness of CHIPS-dependent referral and feedback systems
- g. Effectiveness of community-led integrated disease surveillance and response systems
- h. Community roles in improving health systems governance and accountability

The Programme will be used to assess the relationship between socio-demographic characteristics and community health outcomes. Economic evaluation studies of the CHIPS Programme will provide empirical evidence to ensure optimal utilisation of resources. There will be investments in operations and implementation research to address implementation challenges and best strategies for service delivery. Relevant departments of FMoH and NPHCDA will coordinate research for CHIPS in collaboration with other stakeholders. Outputs of all research on CHIPS Programme will be published on open-access platforms and in formats relevant to specific audiences including local communities.

4.8 Programme Management

4.8.1. Governance

The governance structure of the CHIPS Programme shall cut across all three (3) tiers of the Nigerian

CHIPS PROGRAMME GOVERNANCE STRUCTURE

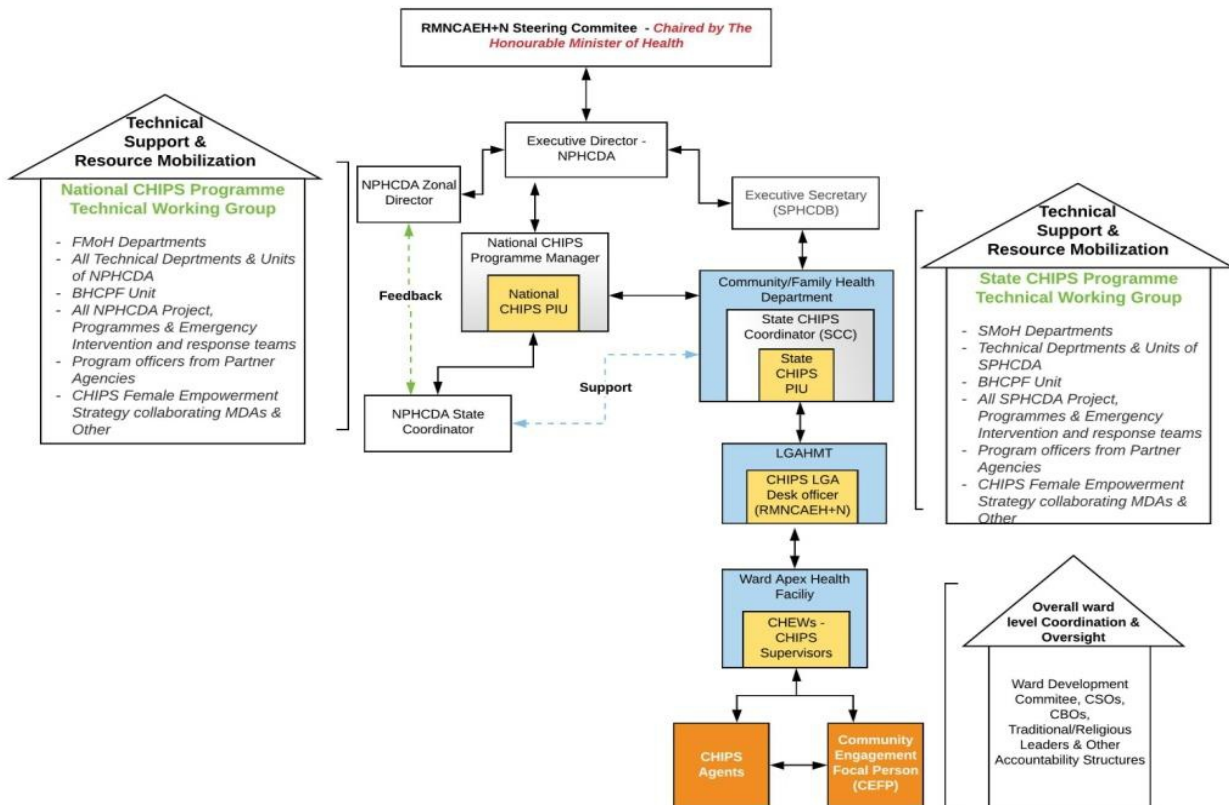


Figure 7: Governance structure of the CHIPS Programme

a. National Steering Committee:

This committee shall be headed by the Honourable Minister of Health with the Executive Director of NPHCDA as Secretary. The committee shall be responsible for strategic direction and decision making as regards the CHIPS Programme. They will also approve policy guidelines and standards for implementation of the Programme across all 36 states of the federation and the FCT.

b. National Team:

The Executive Director of NPHCDA shall head the National team with the Director, Community Health Services Department, Programme Technical Advisors and NPHCDA Zonal Directors as members. The National team will develop policy related guidelines and standards for approval by the steering committee. The National team will also be responsible for resource mobilisation and technical oversight to States for Programme implementation and also for National level monitoring and evaluation of the programme. The CHIPS Programme Unit will be headed by the CHIPS Programme Manager, supported by Deputy Programme Managers drawn from the two (2) components of the Programme namely: Demand Creation and Health Service Provision (NPHCDA) and Women Empowerment (Female Literacy Programme and Skills acquisition & Income Generation). They are responsible for coordinating the day to day programme activities at the National level and report to the Executive Director through the Director, CHS. The NPHCDA PHC Top Management Team Meeting will serve as a platform for providing support to the CHIPS Programme, this will involve monitoring and evaluation, advocacy as well as resource mobilization etc.

c. Zonal Team:

The Zonal Team headed by the Zonal Director of NPHCDA has the responsibility of coordination at zonal level and provide technical assistance, supportive supervision, capacity building and support in monitoring and evaluation of the Programme to the states within their zone and report to the Executive Director NPHCDA. They will provide zonal oversight of the Programme and conduct zonal review meetings.

d. State Team:

The State team will adapt or adopt the National policy, mobilise resources, coordinate implementation, guarantee Programme accountability, monitor and evaluate the CHIPS Programme at the state level. The State CHIPS Programme Unit will be headed by the CHIPS Focal Person, supported by Co- Focal Persons the two (2) components of the Programme namely: Demand Generation and Health Service Provision (SPHCDB) and Women Empowerment (Female Literacy Programme and Skills acquisition & Income Generation). They will be responsible for coordinating the day to day programme activities at the State level and report to the Executive Secretary (SPHCDB) through the Director PHC/CHS. The State PHC Top Management Team Meeting will serve as a platform for providing support to the CHIPS Programme at the State level, this involves monitoring and evaluation, advocacy and resource mobilization, programme accountability and sustainability.

e. The LGA Team:

The LGA team is headed by the PHC Coordinator. The Local Government Area Health Authority Management Team (LGHMT) comprises of the PHC Director, Deputy PHC Coordinators and other technical Officers. The team shall be responsible for the implementation of PHC activities at the LGA level. A CHIPS Desk Officer, supported by Co-Desk Officers at the LGA level shall be assigned to collate and verify facility-level data, develop micro-plan, implement effective community entrance, strengthen WDC, support in monitoring and evaluation and ensure smooth operationalisation of the CHIPS Programme.

f. Ward Team:

The ward team comprises of the Focal PHC Facility staff, Ward Development Committee (WDC), Ward Focal Person, traditional and religious leaders, CBOs, CSOs and other key community structures and is headed by the Officer in Charge of the focal PHC with support and oversight from the WDC, headed by the WDC Chairman. The team shall provide oversight function for the CHIPS Programme in their respective wards under the supervision of the LGA. At the monthly meeting of the WDC, they should receive reports and discuss CHIPS Programme related activities and communicate to the LGA Team. In a defined ward, a focal PHC shall serve as a hub for referral, stock and replenishment of commodities. Staff from the focal PHC will be designated to monitor, supervise and mentor the CHIPS Agents and CEFPs.

4.8.2. Rewards and Sanctions

a. Rewarding CHIPS Personnel:

This can be done by recognising, awarding and celebrating outstanding CHIPS personnel and healthcare workers supporting the CHIPS programme at all levels.

b. Sanctioning CHIPS Personnel:

Clear sanctions shall be applied where any implementing entity falsifies data or engages in fraudulent practices. CHIPS Agents, CEFPs and supervising CHEWs or designated health officer

shall be sanctioned to various degrees based on firstoffence, secondoffence and thirdoffence as applicable. Integrated Supportive Supervision (ISS) is to be conducted to evaluate the performance of the CHIPS Agents as well as of CEFPs and officers involved in the programme at different levels, to ensure that the quality of services meets the desired performance standards. Sanctions shall be imposed based on the degree of severity of the offence as determined by relevant stakeholders (see Appendix VI). Sanctions range from a warning, a suspension, a reduction in stipend, to removal from the Programme. (See Appendix VI for sanctions and rewards).

4.9 Financial Management

The implementing entities (NPHCDA, SPHCDA, LGAs, Wards and Health Facilities) are required to maintain accurate financial management systems including accounting, financial reporting, and auditing.

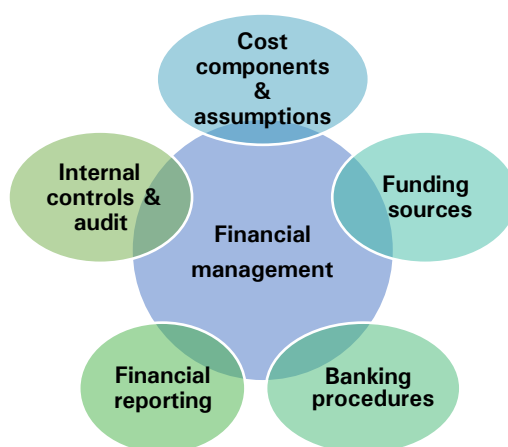


Figure 8: Components of Financial Management

This ensures that accurate, reliable, relevant, understandable and timely information is provided to all stakeholders regarding programme resources, expenditures, assets, liabilities and transactions. This information will enable the implementing entities to plan, manage and monitor the programme activities to achieve set objectives, as well as to ensure that funds are judiciously utilised. The SPHCDA shall manage the funds at the State level for the implementation of the CHIPS Programme in each of the 36 states of the Federation and the FCT. The SPHCDA shall provide to the NPHCDA periodic financial reports of the programme accounts and statement of expenditures audited by the standards of auditing procedures. Banking procedures, financial reporting, internal control and audit mechanisms for the CHIPS Programme should be as outlined in Memoranda of Understanding (MoU) with relevant stakeholders and Standard Operating Procedures (SOPs) for implementation of PHC programmes in the States.

4.10 CHIPS Commodities Distribution Chain

NPHCDA should strengthen and leverage on the existing procurement system for commodities supply chain at all levels. This is to ensure price reduction through volume discounts, availability and consistency of supply. The states can join in and procure from these suppliers to achieve economies of scale. Where the states procure the commodities, such commodities are supplied directly to state warehouses before delivery to health facilities. The following schematic outlines the distribution chain for CHIPS commodities. The system follows the existing National Routine Immunization commodities storage and distribution system (See Appendix III for list of commodities).

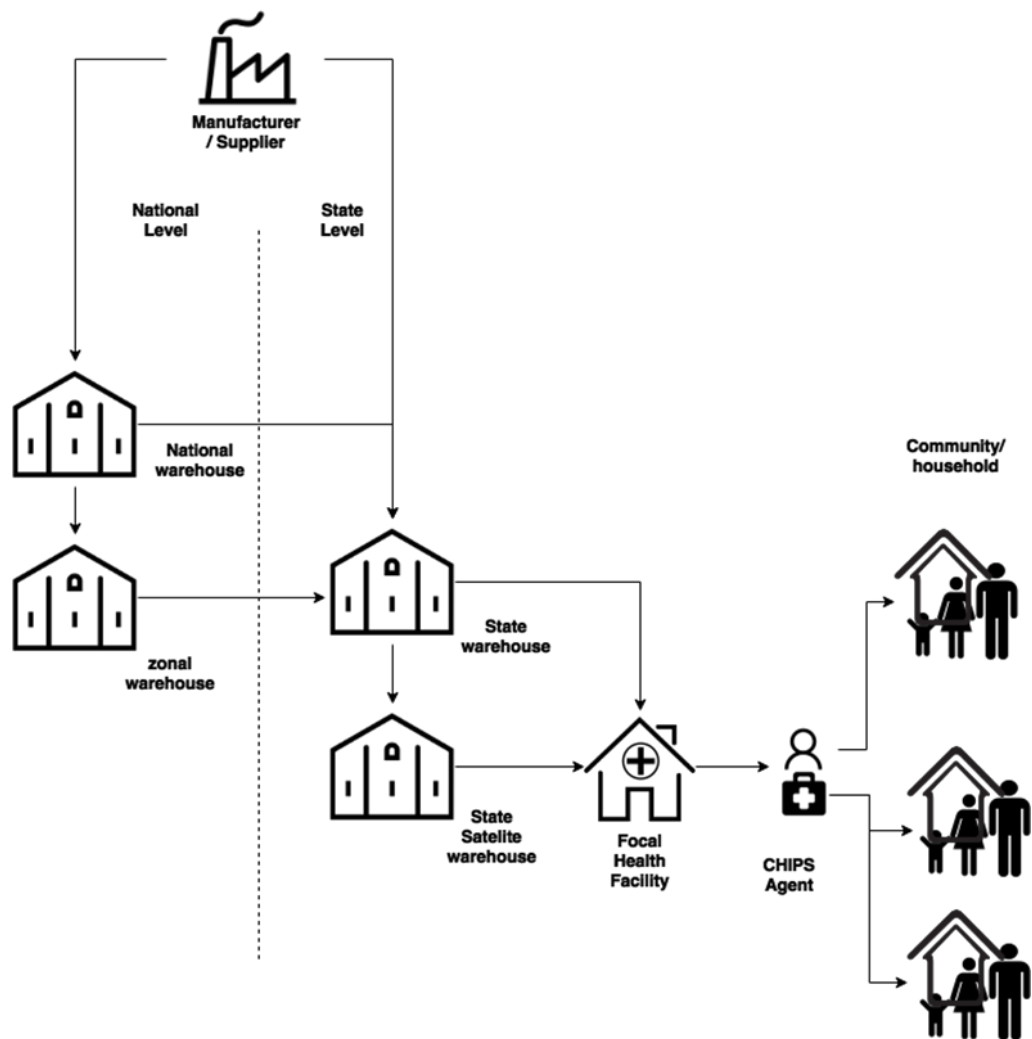


Figure 9: CHIPS Programme commodities supply chain

Appendix IV provides a list of commodities for CHIPS Personnel.

NATIONAL WAREHOUSE

National Strategic Cold Stores (NSCS Abuja, Lagos, and Kano) as the proposed three hubs system shall be utilised as central warehouses for the CHIPS Programme commodities. All procured commodities are delivered to the central warehouses directly from suppliers/donors.



ZONAL WAREHOUSE

As needed, the three additional zonal level immunisation stores (Enugu, Warri and Bauchi) may serve as transient storage locations. For other PHC health commodities and supplies, the zonal/axial warehouses (Lagos, Abuja, Sokoto, Gombe, Cross River and Imo) may be used as a sub-level of commodities storage/warehouses. The commodities may be distributed to states and health facilities based on the distribution plans.



STATE WAREHOUSE

The State warehouse could either receive the commodities directly from the national warehouses, Zonal warehouses, pharmaceutical manufacturers and/or suppliers. The states can also procure directly and distribute through the existing supply chain system. The states forecast commodities required using the demand pattern of facilities within LGAs.

LGA WAREHOUSE

The States can either distribute the commodities directly to the focal facilities or through LGAs/satellite stores. CHIPS LGA desk officer should supervise and document the distribution of the commodities



FOCAL HEALTH FACILITY

Health facilities receive commodities from either the State or the LGA/satellite store. The health facilities allocate the commodities to the CHIPS Agents. The OIC ensures allocation of the full complement of commodities at the first instance and subsequently based on requisition, the commodities are allocated to the CHIPS Agents. The OIC manages inventory and stock levels and transmits the stock levels information to the LGA CHIPS focal person.



CHIPS AGENTS

The CHIPS Agents receive the commodities from the supervising CHEWs. They are expected to document quantity received and the way it is utilized. The CHIPS Agent's utilization register would be verified before the commodities are re-stocked.

The CHIPS Programme provides an integrated service model to actively transition existing and future resources in a more cost-efficient manner. This should be coordinated in the states using the Logistics Management Co-ordinating Unit (LMCU) structure that exists in all states and FCT. Efforts should be made to work with the Pharmaceutical Manufacturers Group of Manufacturers Association of Nigeria (PMG MAN), who is part of the Primary Health Care Revitalisation Supply Chain Committee (PHCrSCC). Working with the PMG MAN provides an opportunity to negotiate lower costs of health commodities and to secure distribution-cost reduction. By so doing, the Agency takes note of products that have been forecasted, procured, manufactured and available in Nigeria. Commodities should be branded with Federal Government logo to ensure commodity-security. However, in security-compromised regions, where the safety of CHIPS Agents may be threatened, it is advisable to use unbranded commodities. States are advised and encouraged to have a strong central medical store to promote robust warehousing and distribution systems for all products.

NPHCDA should have visibility on procurements made by the State and LGA under this programme, working with the Logistics Management Coordinating Unit (LMCU) at State and National levels. Procurement should be based on work plans developed for defined periods. The procurement plan should be in tandem with the requirements of the Bureau for Public Procurement and State procurement laws as applicable, in line with the procurement SOPs in Appendix IV. For commodities provided by donor agencies, an inventory of all commodities should be properly documented at the SPHCDA and NPHCDA. This is useful in conducting gap analysis for forecasting to ensure effective planning and avoidance of stock outs, overstocking and wastage.

4.11 Supportive Supervision

Integrated supportive supervision shall be carried out at different levels. The first level is the supervision of the CHIPS Agents by the CHEWs and a supervisory checklist has been developed to guide the process.

Areas to be supervised include:

1. Logistics and commodity availability
2. Community engagement
3. Service provision
4. Data verification

Table 5 outlines the levels and frequency of the supervision.

Table 5: Roles and Responsibilities of Supervisors at Different Levels

RESPONSIBLE	LEVEL	ROLE	FREQUENCY OF SUPERVISION
Supervising CHEW	Community and Ward	<ul style="list-style-type: none"> • Integrated supportive supervision of CHIPS Agents • Integrated supportive supervision of CEFPs • Data collation and submission to Ward Focal Person 	Fortnightly
OIC of CHIPS Focal Facility	Community and Ward	<ul style="list-style-type: none"> • Supportive supervision of CHIPS Agents and CEFPs • Commodity Requisition 	Fortnightly
Ward Focal Person	Ward	<ul style="list-style-type: none"> • Data collation and submission to LGA CHIPS focal person • Disease Surveillance 	Monthly
Ward Development Committee	Ward	<ul style="list-style-type: none"> • Commodity security • Oversight function • Sanctioning and Reward of Personnel 	Monthly
Community Based organizations	Ward and LGA	<ul style="list-style-type: none"> • Programme monitoring • CHIPS Agents and CEFPs • WDCs • Supervising CHEWs • Commodity supply and security 	Monthly
LGA CHIPS Team	Ward and Community	<ul style="list-style-type: none"> • Supportive supervision of CHIPS focal facility • Supportive supervision of CHIPS Personnel • Data collation and submission 	Monthly
State CHIPS Team	LGA, Ward and Community	<ul style="list-style-type: none"> • Supportive supervision • Data collation and submission • Commodity supply chain management 	Quarterly
National Team	State, LGA, ward and community	<ul style="list-style-type: none"> • Supportive supervision • Data validation and quality check 	Bi-annually

4.12 HMIS Monitoring and Evaluation

The Monitoring and Evaluation (M&E) framework for tracking progress of the CHIPS Programme implementation is based on the global M&E operational framework which links inputs to intended results, ensuring that considerations are made for influencing and facilitating factors. The general M&E framework is illustrated in the figure below:

The health sector M&E framework takes into account the wide range of the health sector indicators at various levels and layers of implementation of health programmes and their activities. The monitoring framework for tracking progress is informed by the need to comprehensively monitor and review the entire health sector reform and progress made towards quality of life improvement. Consequently, core indicators have been identified to guide analysis of sector performance progress along thematic areas and also across the indicator domains of health programmes – input, process, output, outcome and impact, as much as possible. Core indicators are defined and structured to inform on and/or compare trends across the different domains.

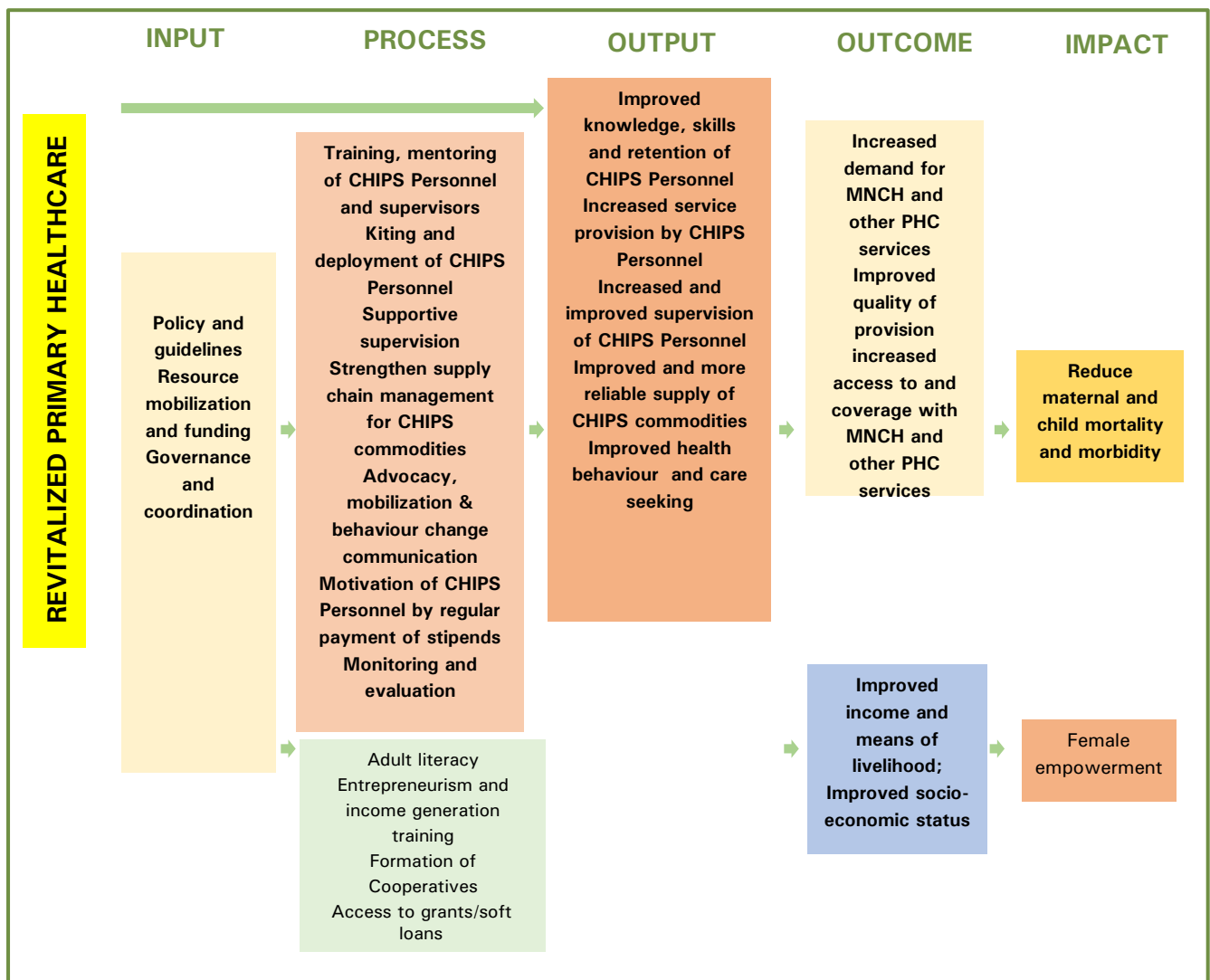


Figure 10: Monitoring and Evaluation framework of the CHIPS Programme

The availability of timely and reliable data from the CHIPS Programme is the cornerstone of community-based decision-making. This section outlines the CHIPS Programme data collection, data flow and the guideline for how state will monitor and evaluate the Programme. This will also serve as a guide to state in setting up and implementing a robust system to monitor programme outputs, identify challenges and develop practical solutions to address them.

The section includes:

- Recording and collecting community data
- Data Reporting
- Data Quality Assurance
- Indicators
- Data flow
- Monitoring performance on the programme
- Evaluation

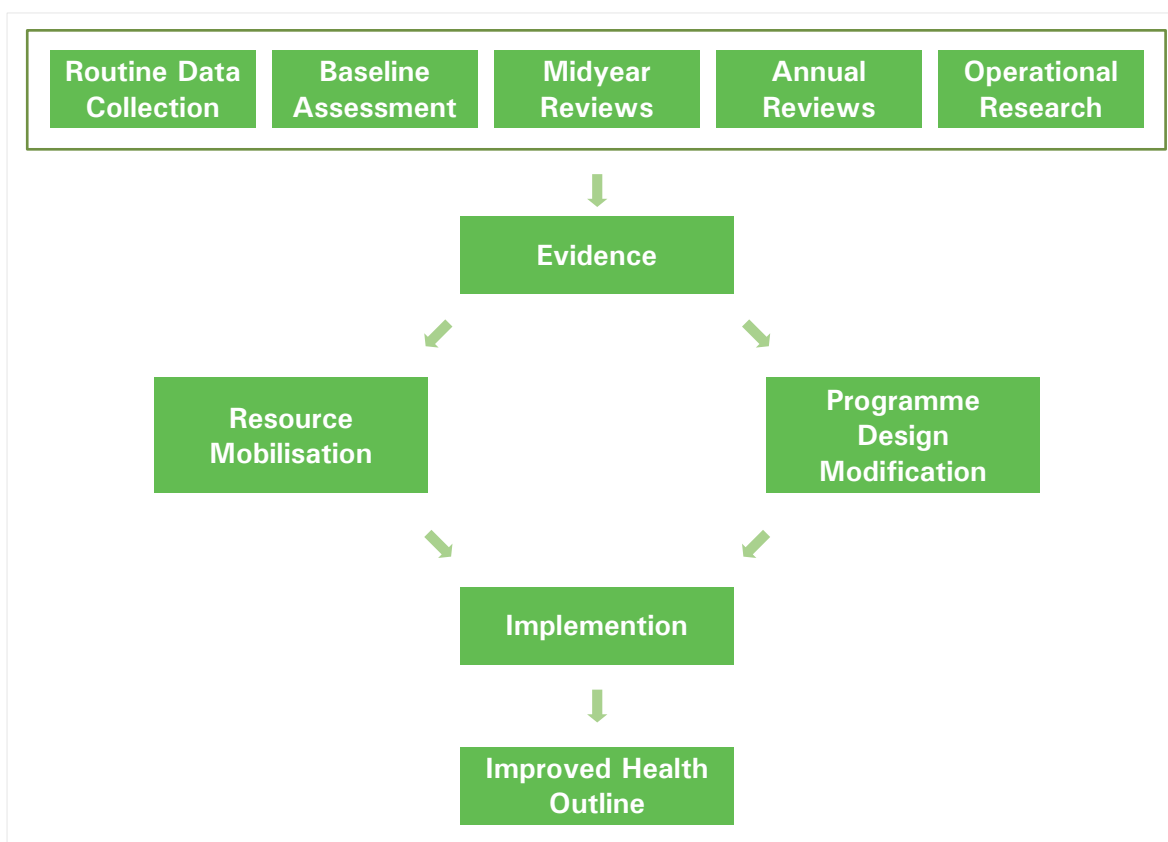


Figure 11: CHIPS Programme: Linking evidence to implementation for improved Community Health Outcomes

4.12. 1. Recording and Collection of Community Data

- Following training, CHIPS Agents will map their communities, number houses and create a listing of households within their catchment area. The Household Register is designed for CHIPS Agents to create a listing of households within their catchment areas, register household members and record key socio-demographic information on members of households, Household WASH practices and updates on births, deaths and migrations.

- b. As CHIPS Agents conduct home visits, they are expected to identify pregnant women in their communities. Once identified, CHIPS Agents will register these pregnant women in the 1000 Days Checklist. The 1000 Days Checklist records uptake of services at health facility critical during pregnancy and up to when the child is 24 months (2 years) – a period which corresponds to 1000 days. It serves as a community-based record of utilization of services vital to pregnant women and children up to 2 years of age and guides the CHIPS Agents to provide time targeted counselling to pregnant women and children under – 2 years.
- c. After the pregnant woman is identified and registered, the CHIPS Agent will give her a Mother's Card. The Mother's card is a home-based record that documents services received at the health facility and in the community (from CHIPS Agents) by a pregnant woman during the course of the pregnancy. It serves as a visual cue for the CHIPS Agent on the appropriate counselling to provide to the pregnant woman and documents the date when the recommended counselling was done and provides the pregnant woman with pertinent information related to her pregnancy including – ANC/PNC Appointments, Information on Emergency Transport Services (ETS).
- d. CHIPS Agents provide Home-Based Cards to households. Home-based cards document/record services provided by the CHIPS Agents to the household to be kept permanently in the home as a home-based record of service provision.
- e. CHIPS Agents record their home visits in the Encounter Register. The Encounter Register records basic health services provided by CHIPS Agents and utilization of critical health facility services by the programme target population. The CHIPS Agents has two (2) Encounter Registers - Maternal & Child Health (for services provided by CHIPS Agents to pregnant women and children under 5 years) and Household (for service provision which is not specific to pregnancy and child hood but general to all household members such as Counselling on WASH, Adolescent Health, Disease Prevention, supporting community surveillance, monitoring maternal and child deaths and First Aid).
- f. CHIPS Agents are expected to dispense some medicines and commodities to target population as needed. Community Commodity Dispense Form records medicines and commodities dispensed by the CHIPS Agents and information on recipients to be used for verification.
- g. Referrals made in the community to health facilities by CHIPS Agents are to be documented in the Referral Form. Clients are given a copy of the referral form to take to the health facility. Following treatment, the health worker completes a feedback slip which is returned to the CHIPS Agent.
- h. CHIPS Requisition and Issuance form records commodity and supply requests from focal health facility and documents commodities received by CHIPS Agents from supervising CHEW.
- i. Monthly Activity Summary Form is used by the CEFPP to summarize and collate CHIPS Agents service delivery and referral activities in the ward.

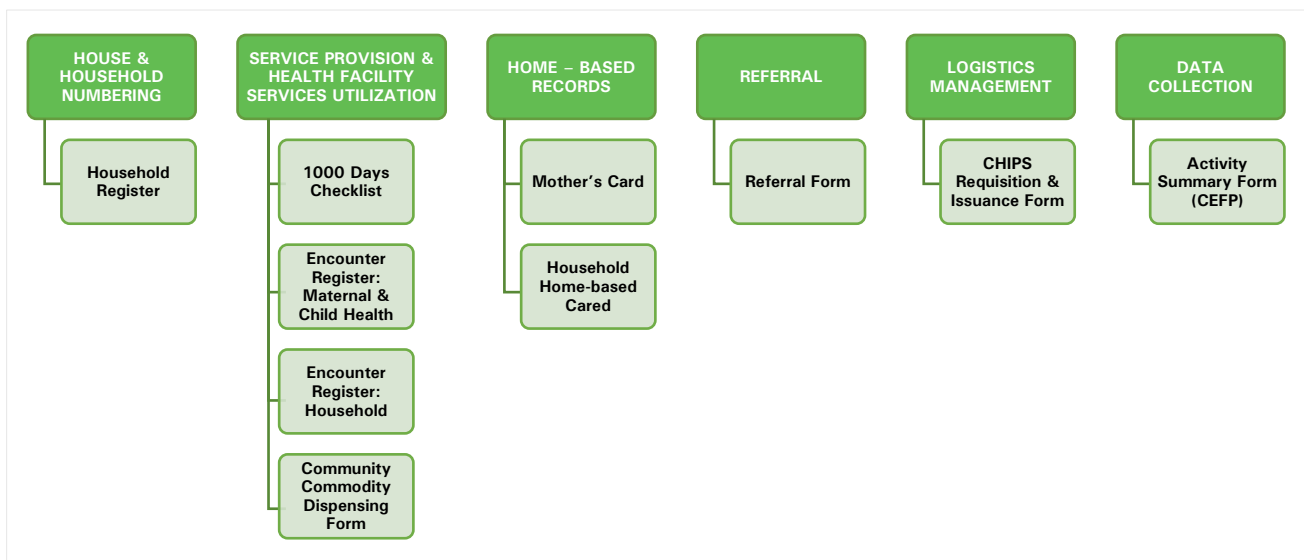


Figure 12: CHIPS Programme Data Collection Tools

4.12.2. Data Reporting

- a. Data to be reported on the CHIPS Programme includes service provision by CHIPS Agents, health behaviours of the community, community surveillance of priority diseases as well as maternal and newborn deaths.

The programme shall employ both paper-based and electronic reporting methods as outlined below:

- i. **Paper-Based Reporting:**
Following the collection of data from community by CEFPs using the Monthly Activity Summary form, hard copies are submitted to the facility where they are used to validate data, report and analysis for feedback to the community.
- ii. **Electronic Reporting:**
Data recorded by CHIPS Agents will be entered into the National Instance for CHIPS on DHIS 2. The National Instance is a programme specific platform used to collect data from the CHIPS Programme, It reports data for use in decision making by all governance levels (LGA, State and National). The National Instance is then able to track critical life events (e.g. pregnancy, immunisation, growth monitoring) to provide more focused care at the community level as well as provide data for use by all levels for planning, decision making and monitoring.

4.12.3. Data Quality Assurance

- a. **Verification of Community Data recorded by CHIPS Agents:**
The Community Engagement Focal Persons (CEFPs) are responsible for conducting routine verification of quality on data recorded by the CHIPS Agents before entry into DHIS2. This is conducted monthly using Random or Purposive Selection outline below:
 - i. **Random Selection:** CEFPs will select 40% of the CHIPS Agents assigned to them to conduct verification of their data. Having selected these, the CEFPs will randomly verify 30% of the data generated by these CHIPS Agents. This is the preferred method in the initial stage of the CHIPS Programme implementation.

- ii. Purposive Selection: CEFPs will identify CHIPS Agents that have data quality issues and prioritise them for data verification.

b. WDC Validation of Community Data:

- i. The WDC randomly reviews data collected by CEFPs during their monthly meetings. This is to provide community-level verification of data as well as feedback to key stakeholders in the community.
- ii. The WDC will designate a member to routinely review and endorse the data with the CHEWs in the health facility before it is reported on the National Instance. This requires that hard copies of the monthly activity summary sheet submitted to the PHC be endorsed by the designated WDC member after review.

c. Validation of Data Collected by the CEFPs: The Supervising CHEW or designated health officer at the Focal PHC facility has the responsibility of randomly verifying data entered into National Instance by the CEFPs. The supervising CHEW also validates the data regenerated by the CHIPS Agent during supervisory visits by randomly checking the household home-based cards to see level of agreement with data entered in the encounter registers.

4.12.4 . CHIP Programme Indicators

The key indicators that will be used in Monitoring and Evaluation of the programme are:

i. Impact indicators

a. Health indicators

- Maternal mortality ratio
- Infant mortality rate
- Neonatal mortality rate
- Under-five mortality rate
- Incidence/prevalence rates of under-five morbidity rates for common childhood illnesses (diarrhoea, malaria, pneumonia, malnutrition)
-

b. Female empowerment indicators

- Wealth quintiles of females
- Purchasing power of females

ii. Outcome indicators

- Immunization coverage
- Proportion of women who delivered in the last 2 years that had ANC
- Proportion of women that delivered in the preceding 2 years that had at least 8 ANC visits
- Proportion of women that delivered in the preceding 2 years that delivered in a health facility
- Proportion of deliveries in the preceding 2 years whose deliveries were supervised by a skilled birth attendant

iii. Output indicators

- Number of CHIPS personnel trained
- Quantum of services provided by CHIPS personnel by type of services providing
- Number of CHIPS personnel trained in income generation
- Number of CHIPS personnel linked to adult literacy classes

iv. Input indicators

- Proportion of states with budget lines for CHIPS Programme
- Proportion of the PHC budget allocated to the CHIPS Programme
- Proportion of states paying stipends for the CHIPS Programme

v. Process Indicators

- Proportion of states that have developed state level plans for the CHIPS Programme
- Proportion of states with the proposed coordinating/governance structure
- Number of community based health workers transitioned to CHIPS Programme in implementing states
- Proportion of states implementing CHIPS Programme
- Proportion of wards in a State implementing CHIPS Programme
- Number of partners supporting the CHIPS Programme
- Proportion of wards implementing the CHIPS programme with CBOs monitoring CHIPS Programme
- Proportion of wards implementing CHIPS programme with functional WDCs regularly reviewing CHIPS personnel work during their meetings
- Proportion of trained CHIPS personnel trained and still providing service
- Proportion of states paying stipend regularly to the CHIPS personnel
- Availability of expanded CHIPS PIU that reports to Child Survival Sub-Committee of National Child Health Technical Working Group (NCHTWG)
- Availability of expanded CHIPS PIU that reports to RMNCH Technical Working Group
- Availability of expanded State CHIPS PIU that reports to Child Health Technical Working Group (NCHTWG)
- Availability of expanded State CHIPS PIU that reports to RMNCH Technical Working Group
- Proportion of CHIPS Agents implementing female empowerment programmes for the CHIPS

4.12.5. Data Flow

The Programme data begins with the CHIPS personnel (CHIPS Agents and CEFPs) as they serve as a link between Communities and Primary Health Care Facilities. The CHIPS Agents shall record data from their work in the community. Community Engagement Focal Persons (CEFPs) shall collect data from CHIPS Agents and then reconcile, summarise and report the data from the CHIPS Agents into the National Instance for CHIPS on DHIS 2.

The focal PHC facility is the hub for all CHIPS personnel working in that ward. The focal PHC facility coordinates CHIPS Programme operations including monitoring, supervision, and commodities supply chain management in each ward. In each focal PHC, two experienced health workers (preferably CHEWs) will serve as the focal person for the programme in the ward. Figure 13: CHIPS Programme Data flow The Supervising CHEWs shall validate and provide a final level of approval for the data on the National Instance for CHIPS on DHIS 2 using the hard copies submitted to the facility. Data on the National Instance for CHIPS on DHIS 2 is available for LGA, State and National levels. Programme logistics data along with implementation reports should move through the CHIPS governance system from the Focal PHC Facility to the LGA (CHIPS Desk Officer) and finally to the State (CHIPS Focal Person) for planning and decision making.

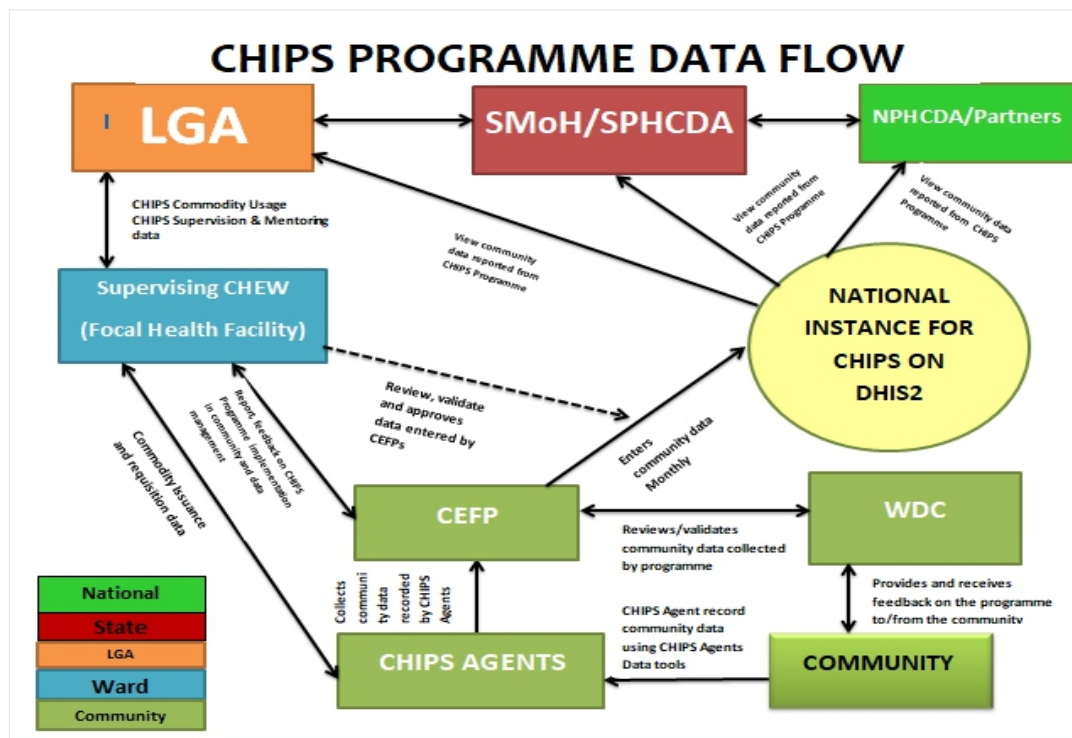


Figure 13: CHIPS Programme Data Flow

4.12.6. Monitoring Performance on CHIPS Programme

CHIPS Agents Data Review:

The CEFPs are the direct recipients of data from CHIPS Agents, they should therefore monitor the CHIPS Agents every two weeks on data related issues. This also provides an opportunity for the CEFPs to review the data recorded by the CHIPS Agents frequently, to enable timely response when issues are flagged.

Monthly Review Meeting:

The supervising CHEW or designated officer shall facilitate a monthly meeting for all CHIPS Personnel in the ward especially those in Hard-to-Reach Areas. The meeting should cover:

- i. Performance Review of CHIPS Personnel
- ii. Feedback on data collected by CHIPS Agents
- iii. Discussion of challenges to service delivery by CHIPS Agents during the month
- iv. Updates to CHIPS Agents on guidelines and other technical details relating to the programme

A Ward Review Meeting report that highlights issues in the programme during that month as well as providing basic analysis of programme data for that month is developed and submitted to the LGA desk officer.

Ward Development Committee Meetings:

The WDC shall monitor CHIPS personnel performance and that of the supervising CHEW/designated health officer. During monthly WDC meetings, the CHIPS Programme shall form part of the discussions of the meeting including a review of community data trends and service provision by the CHIPS Agents. The WDC will also identify a member responsible for reviewing and endorsing the community data recorded with the supervising CHEW before being reported.

LGA Monthly Review Meeting:

The LGA CHIPS Desk Officer with the support of the LGA M&E Officer and other members of the LGA PHC team shall facilitate a monthly review meeting with the Supervising CHEWs or designated health officer and their respective OIC in attendance. All areas of CHIPS implementation, data management and capacity of the supervisors shall be reviewed.

Quarterly Data Quality Assurance:

A Data Quality Assurance (DQA) exercise conducted by a team comprised of members from the State and the National PHC team (including partners operating at the State and LGA level shall be conducted quarterly. A CHIPS Programme DQA checklist shall be used to perform data quality assurance, document the findings and proffer corrective action plans for data quality improvement.

4.12.6.1. Role of Civil Society Organizations in CHIPS M&E

The CHIPS Programme has proposed an additional layer to the monitoring and supervision by engaging CSOs to support the existing structure of the health system. The CSOs will carry out administrative and programme monitoring roles, while technical monitoring and supervision remains with health workers. The rationale is that the CSOs are already present in the community and have an understanding of how the community works. They are therefore in the best position to support the system to ensure effective monitoring of the programme. The CSOs shall be overseen by the LGHMTA and submit monthly reports to them.

The roles assigned to CSOs include:

- a. Verification of CHIPS Agents and CEFPs work efforts
- b. Sampling of households to ensure they have access to PHC interventions provided by CHIPS Agents including
 - i. Home visits by CHIPS Agents within the timeframe
 - ii. Availability of Home-based cards in households
- c. Commodity monitoring
 - i. Verify drug utilisation by CHIPS agents within their catchment areas
 - ii. Verify CHIPS Agents drug stocks (with CHIPS Agents and in facilities)
- d. Data verification and validation
 - i. Data verification for data recorded by CHIPS Agents by CEFPs
 - ii. Data validation of data collected by CEFPs
- e. Monitoring, Supervision and Programme management
 - i. Check if CHEWs are conducting regular supervision of CHIPS Agents as stipulated
 - ii. Check if review meetings are conducted within stipulated time at each level (Ward, LGA)
 - iii. Check if WDC meetings are held regularly
 - iv. Check if CEFPs provide regular reports to WDC
 - v. Monitor Community Satisfaction
 - vi. Periodically obtain feedback from community regarding perceptions of the programme and satisfaction with CHIPS Agents and services

4.12.7. Monitoring and Evaluation of the CHIPS Programme

Monitoring and Evaluation (M&E) is a process that helps to improve programme performance and achieve results. Its goal is to improve current and future management of outputs, outcome and impact. It is mainly used to assess the performance of projects Institutions and Programs set up by Governments and NGOs as it establishes links between the past, present and future actions.

4.12.7.1. Programme Monitoring

The Programme shall be monitored with routinely collected community level data, reports of supervision and review meeting at different levels. An evaluation of the programme to determine the

level of achievement of programme objectives and its impact should be done periodically as outlined below.

i. Baseline Assessment:

A pre-implementation assessment to be conducted in each state to generate information for planning and provide baseline data that will aid the monitoring the progress of the Programme over time. The baseline assessment is vital as it ensures accountability to partners and other stakeholders. Also, the information obtained from the assessment will serve as a basis for setting performance targets at all levels.

The CHIPS Programme baseline assessment template will be disseminated to all implementing states for the baseline assessment. Due to the challenges of conducting a national survey with a sample size large enough to determine the baseline values of the indicators at ward level, existing data sources such as HMIS data available on DHIS2, recent household surveys and related studies conducted should be used to determine the baseline for each community and ward. Where data cannot be obtained, it is recommended that trained personnel are deployed to the facilities to review the relevant HMIS data collection tools and extract the information needed.

ii. Midyear Review:

During the implementation phase of the programme, FMoH and NPHCDA shall support states to conduct a midyear comprehensive review of the programme. This will enable identification of gaps if there are any and provide suggestions to bridge the gaps with the aim of improving programme efficiency and impact. All the states shall use a standardised template to ensure all the critical components of the programme are reviewed.

iii. Annual Review:

An annual review shall be conducted at the National level. At this level, the stakeholders from the States will meet to identify gaps in the programme implementation, best practices, lessons learned and proffer solutions to problems identified to improve programme efficiency and impact.

4.12.7.2. Programme Evaluation

External Evaluation: It is recommended that external evaluation should be done every 3 years to determine the relevance, scope, effectiveness, efficiency, outcome and impact of the Programme. The result of each evaluation should be disseminated to all stakeholders and used for programme improvement.

05

GOVERNANCE AND COORDINATION

5.0 GOVERNANCE AND COORDINATION

5.1 Roles and Responsibilities

The FMOH and NPHCDA's roles and responsibilities in the harmonisation and operationalisation of the CHIPS Programme will be guided by the statutory roles and responsibilities outlined for the two bodies in line with their mandates/Act setting them up.

The FMOH shall:

- a) Provide policy and strategic direction through policy statements and national health strategies on primary health care, including community-based PHC programming in the country. This should include the development of a national policy on institutionalisation of community based primary health care
- b) Lead the development of a roadmap for alignment of community-based programmes into the CHIPS Programme
- c) Work with the NPHCDA in defining standards and regulation of practice of the CHIPS Programme
- d) Support resource mobilization and deployment for the planning and implementation of the CHIPS Programme
- e) Support the development of the CHIPS Programme Strategic Plan.
- f) Jointly Coordinate RMNCAEH + N focused research under the CHIPS Programme
- g) Work jointly with the NPHCDA in the conduct of integrated supportive supervision and monitoring and evaluation of the CHIPS Programme
- h) Work jointly in the development and review of the training materials

NPHCDA shall:

- a) Work with the FMOH to develop the roadmap for harmonization/alignment of community-based programmes with the CHIPS Programme, set standards and regulate practice of the CHIPS Personnel
- b) Develop the CHIPS Programme Strategy
- c) Engage with partners, mobilise and deploy resources for the CHIPS Programme
- d) Provide leadership and direction in the implementation of the CHIPS Programme at national and sub-national levels
- e) Develop the monitoring and evaluation plan and work with the FMOH to implement it

The table below gives the details of roles and responsibilities of the two parties.

Table 6: Roles and Responsibilities of FMoH and NPHCDA

S/No	Roles and Responsibilities	LEAD	
		NPHCDA	FMoH
	Leadership and Coordination		
1	Provide policy and strategic direction		
2	Development/Review of Programme Strategy		
3	Alignment of all Community-based Programs with CHIPS Programme and development of roadmap		
4	Development of Roadmap for institutionalization of community-based PHC (policy)		
5	Development of Strategic Plan		
6	Development of AOPs		
7	Setting standards of practice of CHIPS Personnel		
8	Regulate practice of the CHIPS Personnel		
9	Engagement with partners		
10	Resource Mobilization and deployment		
	Implementation		
11	Day to day running of Programme		
12	Engagement with states and development of work-plans		
13	Provision of technical oversight for the planning of state level CHIPS Programme Activities		
14	Development and Review of Training materials		
15	Coordinate selection of CHIPS Personnel		
16	Review of Training plans and coordination of trainings		
	Research, Monitoring and Evaluation		
17	Development M&E Framework		
18	Receipt of routine programme data		
19	Conduct of Field monitoring and ISS		
20	Conduct of annual Programme review		
21	Research on RMNCAEH + N Interventions		
22	Evaluation		

5.2 Operational Modalities

To guide the smooth operations of this harmonisation the following is proposed:

- a) Create a CHIPS desk at the FMOH
- b) Embed some of the iCCM staff in the CHIPS Programme Implementation Unit (PIU) of NPHCDA
- c) The CHIPS Desk Officer at the FMOH should attend the biweekly meetings of the CHIPS PIU
- d) The Technical Working Group (TWG) for community health programming will be constituted, with membership to include representation from the FMOH CHIPS desk, other MDAs and all partners supporting community-based health programmes. The TWG will meet quarterly
- e) At the end of each year, the CHIPS PIU should lead the process of developing an Annual Operational Plan (AOP). All TWG partners are to commit to its implementation
- f) Prioritize selection of existing CORPs as CHIPS Personnel during implementation in states
- g) Joint integrated supportive supervision and monitoring visits are to be organized by CHIPS PIU and implemented by teams comprising CHIPS PIU, FMOH and partners.

The leadership of FMOH and NPHCDA should jointly engage with partners and mobilise resources for the planning and implementation of the CHIPS Programme. They should prioritise how best to deploy these resources.

5.3 Specific Roles of Stakeholders

5.3.1. Roles of NPHCDA, SPHCDA, LGA and Ward PHC Teams

The implementation of the CHIPS programme shall be coordinated through a model that brings all stakeholders at all levels under one roof to minimise duplication of efforts, reduce inefficiencies, enhance integration and strengthen effectiveness and delivery of results. The NPHCDA shall provide guidance and support for the implementation of the CHIPS Programme. The NPHCDA and SPHCDA, working with partners and other stakeholders, will ensure effective engagement and coordination through the following approaches:

1. High-level advocacy to the various stakeholders (Government, development partners, the private sector, traditional and religious structures etc), at all levels for political commitment, resource mobilisation and buy-in for the CHIPS Programme
2. PHC adoption by the private sector to expand the operational capabilities of the CHIPS Programme
3. The mobilisation of private and development partners to realign their existing investments (especially at Zonal and State levels) to ensure efficient use of resources with the goal of attaining the PHC revitalisation objectives through the CHIPS Programme.
4. Leveraging the strengths and competencies of stakeholders in terms of human resources and technology to improve the functionality of the CHIPS Programme
5. NPHCDA has the responsibility for coordinating setting of guidelines and standards for implementation of the CHIPS Programme across all 36 states of the Federation and FCT.
6. NPHCDA should provide oversight to the 36 States and FCT towards achieving financial accountability and transparency in line with the National framework.
7. The SPHCDA shall coordinate distribution of commodities, payment of stipends and IEC materials.
8. SPHCDA are responsible for stocking and restocking CHIPS commodities.
9. NPHCDA shall support states in the development of a matrix to assess the performance of the CHIPS Personnel and activating a reward and sanction system.

5.3.2. Roles of FMoH, SMOH and Local Government

1. Advocacy to relevant stakeholders to solicit support for the CHIPS Programme.
2. Support the NPHCDA, SPHCDA and LGHMT to ensure implementation of the CHIPS Programme.
3. Carry out oversight on the implementation of the CHIPS Programme and provide guidance where needed (such as data management and use of data for decision making).
4. SMOH should operate within the National framework of financial accountability for the CHIPS programme.
5. Mobilise resources to support the implementation as well as provide oversight on the monitoring and evaluation of the programme.
6. Commit sufficient multi-year resources to ensure sustainability of the Programme.
7. Provide overall technical support for data management, design and implement operational research; and share findings with stakeholders.
8. Monitor overall CHIPS programmatic trends.
9. Conduct National (annual) review meetings.
10. FMoH shall support states in the development of a matrix to assess the performance of the CHIPS Personnel and activating a reward and sanction system.
11. Provide CHIPS Programme essential commodities such as Malaria Rapid Diagnostic Tests (RDTs) kits, respiratory timers, medicines for case management of fever, malaria, diarrhoea and fast breathing as well as other requirements for supervisory activities e.g. vehicles.

5.3.3. Roles of Donor Agencies and Development Partners

1. Provide general support to the CHIPS Programme
2. Support the implementation of the CHIPS Programme
3. Align their objectives and funding with CHIPS Programme
4. Undertake advocacy visits in collaboration with the NPHCDA and SPHCDA to key Government officials and traditional/religious rulers (at various levels).
5. Support the mobilisation of resources for the CHIPS Programme.
6. Provide technical support for the implementation of the CHIPS Programme.
7. Support CHIPS Personnel training at all levels to ensure quality control.
8. Provide support based on aligned interest in bespoke packages such as life-saving commodities, ICT, vehicles for supervision etc.
9. Support the harmonisation of the existing community level human resource structures.
10. Support demand generation services for CHIPS Programme.
11. Engage other stakeholders in sensitising the community about the CHIPS Programme through town announcers, billboards, IEC materials, edutainment and any other available means of community mobilisation.
12. Support activities that optimise the services of CHIPS Personnel such as micro-planning, commodities forecasting, equitable distribution of households and settlements.
13. Support the assessment of service delivery, commodity management and accountability mechanisms of the CHIPS Personnel.
14. Support the development of a matrix to assess the performance of the CHIPS Personnel and activating a reward and sanction system.
15. Provide technical assistance to the harmonisation of CHIPS data tracking tools.
16. Support documentation of lessons learnt and challenges of CHIPS Programme.
17. Participate in the planning and execution of routine ISS in collaboration with FMoH, NPHCDA and other relevant stakeholders at all levels (National, State, LGA and ward).
18. Participate in the design and implementation of baseline, mid-year and annual evaluations in collaboration with NPHCDA.

19. Participate in review meetings at all levels (National, State, LGA and ward).
20. Provide technical and other support for all M&E functions at all levels.

5.3.4. Roles of Civil Society Organisations (CSOs)

CSOs shall support the CHIPS Programme in the following ways:

1. Advocate to Government and other key stakeholders at all levels for securing political commitment, resource mobilisation and buy-in for the CHIPS Programme.
2. Partner with Government and key stakeholders in the design and implementation of the CHIPS Programme.
3. Monitor and hold the Government accountable for compliance with its obligations towards the CHIPS Programme.
4. Monitor ongoing activities of the CHIPS Programme to ensure that they are in line with National guidelines.
5. Support the NPHCDA, SPHCDA and LGHMT to ensure CHIPS Programme implementation.

5.3.5. Roles and Responsibilities of Traditional and Religious Leaders

1. Support community entry and participation towards implementing the CHIPS Programme
2. Promote community engagement in implementation of the CHIPS Programme
3. Participate in the nomination of candidates for screening and selection as CHIPS Personnel
4. Help reduce resistance by dispelling misinformation/ hesitance regarding the CHIPS Programme, thus increasing acceptance and utilisation of services rendered by CHIPS Personnel
5. Engage non compliant members of the community and counsel appropriately
6. Mobilise resources for programme sustainability e.g. by supporting the CHIPS Agents with financial/non-financial incentives
7. Set precedence for achieving National health targets by providing accountability and monitoring at their level

5.3.6. Roles of the Academia

1. Support capacity building of National and State trainers for the CHIPS Programme.
2. Conduct periodic operational research to evaluate the progress and impact of the CHIPS Programme and facilitate learning for other related programmes.
3. Support the review and finalisation of the CHIPS Programme training materials.
4. Supervise and ensure quality assurance at every level of CHIPS Programme training.
5. Support regular refresher training for CHIPS Programme trainers and trainees.
6. Independently monitor the implementation of the CHIPS Programme.
7. Document lessons learnt from CHIPS Programme to improve the quality of services.

5.3.7. Roles of State CHIPS Coordinators (SCC)

1. Set or assign tasks/targets & coordinate working groups, LGA desk officers and any other Programme officer
2. Review & monitor activity plans of all thematic areas in line with set tasks and targets
3. Manage performance of SPIU members & provide feedback to Director.
4. Liaise with relevant individuals to schedule & plan engagement meetings with the relevant Federal level Stakeholders (SMoH, Partners, Public-Private Partnership etc.)
5. Develop concept notes, letters, activity reports, emails and memo for stakeholder management related activities

6. Conduct a stakeholder mapping and analysis for high-level strategic decisions. i.e. Stakeholders
7. Serve as Secretary to the Governance & Coordination WG
8. Frequently liaise with the National PIU State Support officer
9. Maintain the State CHIPS PIU action tracker to ensure all activities are tracked and reported
10. Maintain a database of contact persons for relevant national and state officials
11. Plan CHIPS PIU meetings (Agenda, reports, sending & following up on invitation letters (emails) etc.

5.3.8. Roles of LGA CHIPS Desk Officer

1. Set or assign tasks/targets & coordinate supervising CHEWs in implementing wards
2. Monitor performance of CHIPS Programme implementation in the wards
3. Conduct supportive supervision of wards and communities implementing CHIPS Programme
4. Review ward level activity plans and monitor implementation progress
5. Engage with relevant stakeholders to improve visibility of, secure buy-in and support for CHIPS programme implementation at LGA and ward level
6. Maintain LGA CHIPS Implementation tracker to ensure all areas of programme implementation are tracked and reported
7. Maintain a database of CHIPS Personnel and Supervisors in the LGA
8. Plan CHIPS LGA Review Meetings (Agenda, reports, sending & following up on meeting notification) etc.
9. Provide feedback on CHIPS Programme implementation to LGA PHC Director and State CHIPS Coordinator

5.3.9 Roles of Ward Development Committees (WDC)

1. Facilitate the nomination and selection of CHIPS Personnel.
2. Review of community level data generated by CHIPS Personnel with the supervising CHEWs.
3. Monitor activities of the CHIPS Personnel to ensure optimal performance of daily duties in line with the National Guidelines, SOPs and Job Aids.
4. Implement community accountability mechanism for monitoring CHIPS Agents' activities in line with community norms and values.
5. Mobilise funds and other resources for the community.
6. Put safety measures in place for the CHIPS Agents in security-compromised areas.
7. Endorse consolidated ward level data (by the Chairman or any other designated member).

5.3.10. Roles of Officers-in-Charge (OIC)

1. Work with CEFPs to intensify community-based surveillance for immediate reporting of notifiable diseases.
2. Provide oversight for the CHEWs or designated health officer in supervising and mentoring the CHIPS personnel.
3. Provide oversight for the CHEWs or designated health officer in managing commodities and equipment under their purview.
4. Ensure CHEWs or designated health officer follow up on issues such as unimmunised children, home deliveries etc that are submitted and referred by CHIPS personnel.
5. Provide oversight to ensure CHIPS Programme data quality.
6. Provide monthly supportive supervision to CHIPS Personnel.

5.3.11. Roles of CHEWs or Designated Health Officer

1. Designated to coordinate the CHIPS Programme activities in the ward. .
2. Regular mentoring of CHIPS Personnel in their respective wards.
3. Manage CHIPS Programme commodities in the focal PHC.
4. Provide supportive supervision to CHIPS personnel.
5. Validate community level data collected by CEFPs.
6. Facilitate Ward Monthly Review Meetings with CHIPS Personnel and other ward level stakeholders.
7. Provide regular feedback on the CHIPS Programme to the WDC during the WDC meetings.
8. Represent the ward at the CHIPS LGA monthly review meetings.

5.3.12. Roles of CHIPS Agents

A CHIPS Agent is a community member engaged to perform the following:

1. Influence, promote and offer first-line treatment of common childhood illnesses in the community and support PHC at the community level.
2. Conduct home visits to patients and clients under their care.
3. Provide health education, counselling, and generate demand for health services.
4. Provide basic first aid.
5. Refer clients/patients to the health facility.
6. Conduct follow up visits.
7. Conduct community level data recording.
8. Mobilisation for outreaches and special campaigns.
9. Provide updates on data collection and service implementation (including commodities usage) to supervisors during mentoring and supervision.
10. Ensures timely submission of community level data to Community Engagement Focal Persons.
11. CHIPS Agents shall report notifiable diseases to the CEFP/supervising CHEW or designated health officer who should report appropriately [Ward Focal Person (WFP), who would in turn report to the DSNO].
12. Regularly meet and provide appropriate feedback to supervisors and community stakeholders on services provision.

5.3.13. Roles of CEFPs

CEFPs are community members engaged to perform the following:

1. Provide support to CHIPS Agents in the conduct of their activities as well as special measures to address security challenges.
2. Work with the CHIPS Agents to encourage male involvement in RMNCAEH + N related activities.
3. Address issues of non-compliance to lifesaving health interventions within the community and forward unresolved issues to the ward heads.
4. Facilitate the tracking of community referrals where male involvement is required.
5. Form male support groups to discuss topics such as WASH, HIV, Family Planning, Nutrition, NCDs etc in collaboration with traditional and religious leaders.
6. Support the CHIPS Agents to ensure the recording of quality community level data.
7. Communicate information on community outreach programmes and other health activities to the CHIPS Agents in the ward.
8. Collect community level data from assigned CHIPS Agents and submit appropriately.
9. Verify data recorded by the CHIPS Agents.
10. Mentor CHIPS Agents on community data recording procedures.
11. Collate and Report commodity usage by the CHIPS Agents.
12. The CEFPs shall present the consolidated ward level data at the WDC meeting.

5.3.14. Roles of Social empowerment MDAs

1. Provide Government Leadership role and support skill acquisition.
2. Develop training packages for implementation of social empowerment schemes.
3. Support resource mobilisation.
4. Train, support, and mentor CHIPS Agents on financial independence.
5. Provide grants and loans to CHIPS Personnel.

06

RESOURCES NEEDED FOR THE CHIPS PROGRAMME AND FUNDING OPPORTUNITIES

6.0 RESOURCES NEEDED FOR THE CHIPS PROGRAMME AND FUNDING OPPORTUNITIES

The availability of financial and other resources for implementation of the CHIPS Programme is crucial to its success. It is notable that a significant amount of similar resources is currently expended on the multiple vertical programmes, temporary emergency campaigns, outreaches and interventions of government and partners that seek to reach households at the community level in Nigeria.

6.1 Resource Requirements

The resources needed for the CHIPS Programme are divided into five (5) broad categories including:

1. Allowances for CHIPS Agents: While the key focus of the programme is to promote community volunteerism, Government of Nigeria (GoN) recommends a monthly allowance for transport and communication costs be given to the CHIPS Agents to enable them carry out their duties effectively. Funding can come from single or multiple sources as agreed in the Memorandum of Understanding (MoU).
2. Commodities and Related Items: The commodities are grouped based on predetermined specifications and quantities and include items that deal with prevailing community needs. The commodities are listed in Appendix IV and include First Aid, Maternity (Mama) and RDT Kits, Essential Medicines and other Commodities.
3. Training Costs: Cost of training is considered at the National, State, LGA and Ward levels and includes personnel costs for trainers, supervisors and participants, as well as costs of training materials, hall hire, feeding and accommodation
4. Monthly review meetings: This requires resources for its conduct.
5. Tools:
 - a. Android Devices: This will be used for community level data collection and transmission. It ensures that households and supervisors can communicate with the CHIPS Agents when necessary.
 - b. Printed Materials: These include the CHIPS Programme guide, training documents, Job aids, checklist and data tools.

6.2 Funding opportunities

The CHIPS Programme provides a unique opportunity for improving coordination and harmonisation of multiple programmes at the community level and consequently, improving cost efficiency. It serves as a framework to actively transition resources for multiple vertical programmes and temporary emergency campaigns, outreaches, and interventions that seek to reach households at the community level in Nigeria. Programme implementation requires allocation of start-up funds for the first year and an increase in government funding for PHC in Nigeria.

The private sector, which includes private foundations, can provide funding directly or indirectly through the provision of commodities and kits, equipment, printed materials, and facilitation of training. Given the challenging economic realities in Nigeria, it is also expected that development partners in providing technical and financial support to the country, will align with Government's efforts to improve resource use through integrated and cost-effective approaches that have the potential for achieving value for money.

Various options for mobilising existing and additional resources for aspects of the CHIPS Programme are as follows:

1. Use of the Basic Health Care Provision Fund (BHCPF) to implement specific components of the CHIPS Programme, t
2. Direct allocation of public funds to the programme at all levels of government with the creation of clear budget lines.
3. Direct funding support from the various stakeholders to implementing agencies at all levels.
4. Grants from donor agencies, International and local Non-Governmental Organisations, as well as MDAs and the transition of development partner funding and technical support towards the CHIPS Programme.
5. Adoption of the CHIPS Programme as a high-value community service, by members of the National Assembly and their State counterparts and to channel constituency projects to specific resource requirements.
6. Community mobilisation of funds and other requirements from community members. .
7. Encouraging the Private Sector including private foundations to invest in the CHIPS Programme as a community level approach that holds promise for yielding immense value.

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Appendix I: Detailed Steps for Implementation of the CHIPS Programme

Phase	Steps	Detailed Activity	Responsible	
Pre-implementation/Planning phase	Stakeholder engagement, consensus building and commitment	High-level Advocacy and resource mobilisation	FMoH, NPHCDA, SPHCDA, SMOH, Partners,	
		Sensitisation/engagement with key stakeholders for buy-in and support	FMoH, NPHCDA, SPHCDA, SMOH, LGHMT, Ward PHC Team, Partners	
		Development and contextualisation of plans for States	NPHCDA, SPHCDA, LGHMT, Partners	
		Adaptation of Programme Guide	SPHCDA, LGHMT, Partners	
		Adaptation and finalisation of MoU	FMoH, NPHCDA, SPHCDA, Partners	
	Baseline assessment	Conduct baseline assessment for performance indicators using new and existing data sources	NPHCDA, SPHCDA, LGHMT, Partners	
		Quantification of requirements (commodities, HR, logistics, etc.) and detailed costing	NPHCDA, SPHCDA, Partners	
	Workplan development	Define specific activities within the State	SPHCDA	
		Assign roles and responsibilities	SPHCDA	
		Specify timelines, deliverables, and key performance indicators	SPHCDA	
	Procurement	Procurement of necessary commodities, human resources availability for effective implementation, management information systems	NPHCDA, SPHCDA, Partners, Private Sector	
		Production of CHIPS Programme Guide, Training Manuals and Job Aids	FMoH, NPHCDA, SPHCDA, Partners	
	Programme launch	Flag off the CHIPS programme to demonstrate leadership and set the pace for the commencement of the operational activities at various levels	State Governors and First Ladies	
	Implementation	Training of Master trainers	National Training of Trainers (TOT)	FMoH, NPHCDA, Partners
			Training of State facilitators	NPHCDA, SPHCDA, Partners
Selection of CHIPS Personnel		Community Sensitisation	SPHCDA, LGHMT, Ward PHC Team	
		Selection of CHIPS Personnel based on defined criteria	NPHCDA, SPHCDA, Partners, LGHMT, Ward PHC Team	
Training and deployment of CHIPS Personnel		Ward level training of CHIPS Personnel and Supervisors	NPHCDA, SPHCDA, LGHMT, Ward PHC Team, Partners	
		Deployment of CHIPS Agents	SPHCDA, LGHMT, Ward PHC Team	
Mid-year/Annual Review		Bottleneck analysis by a joint team of Academia, CSOs and partners Review of achievement of objectives by a joint team of Academia, CSOs, and partners	NPHCDA, SPHCDA, LGHMT	

Evaluation	Further Evaluation	Annual evaluation of outputs based on indicators. Joint analysis of reviewed results for programme improvement	NPHCDA, SPHCDA, LGHMT
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Appendix II: Suggested Areas of Adaption of Programme Guide

S/No	Section of PG	Issue	Rationale for adaptation
1	4.4	Criteria for selection of CHIPS Agents	Contextual differences which exist across states in terms of educational qualification of the CHIPS Agents, acceptability of some age groups to provide service and males to enter households may necessitate review of educational qualification level, age range and sex of the CHIPS Agents in each state.
2	4.4	Criteria for selection of CEPFs	To avoid being gender biased, where females can do the job, including effectively engaging with the men, they could be considered. In addition, volunteers with post-secondary qualifications should also be considered.
3	4.6	Female empowerment	Recognising that FMoH, NPHCDA and State PHC Boards do not have the comparative advantage to lead this pillar, states are encouraged to leverage on existing social economic schemes in their states customize the implementation of this pillar.
4	4.7	Training	Currently there are two approaches to the training for the health pillar: <ol style="list-style-type: none"> 1. The complete training comprises an initial one month's training (2 weeks classroom, 1 week practicals and 1 week classroom) that covers all the modules, followed by 3 months structured mentoring. 2. Two weeks training that focuses on RMNCAEH + N with 3 months structured mentoring. Arrangements are made to complete the training later. Depending on resource availability, states could opt for whichever they can afford.
5	4.10	CHIPS Commodities distribution chain	States appear to have different systems for medicines and commodities supply chain. Each state is to assess the system it currently runs and if working for its PHCs, consider integration of CHIPS commodities and supplies into the system. The priority consideration is how to set up a sustainable and functional system that ensures availability (without stock-outs) of CHIPS supplies to the last mile.

6	5.0	Governance and Coordination	<p>1. While the recommendation is to locate the CHIPS Programme in the Department of Community Health Services within the SPHCDA, states are to consider their local context and place the programme in the department where it will be most functional and effective.</p> <p>2. Coordination at the LGA level: the recommendation is that the RH coordinator at the LGA level should coordinate the CHIPS Programme. However, States are enjoined to examine the human resources available at that level and identify the most competent and available person for the work.</p>
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Appendix III: Additional Responsibilities for Effective Coordination

Activity	Responsible person	Deliverable	Frequency	Recipient of the activity report
Complete and submit community HMIS form	CHIPS Agents	Completed community HMIS form	Weekly	CHEW or designated health officer
Collect commodities from CHEW or designated health officer		Adequate quantities of CHIPS commodities	Weekly or as needed	NA
Keep a record of commodities utilisation		Completed commodities utilisation records	Weekly or as needed	CHEW or designated health officer
Address the unresolved issue with CHEW or designated health officer		Completed report form	As needed	Ward focal person (WFP)
Conduct feedback session on community HMIS data	CHEW or designated health officer	Feedback report	Monthly or more frequently as necessary	OIC
Conduct supportive supervision visit		Report (checklist) of supervisory visit	Monthly to 25% of ward CHIPS on a rotational basis	OIC
Forecast and quantify commodities prior to collection by ward CHIPs		Updated SRV and SIV	Monthly or as needed	NA
Conduct joint supportive supervision with WFP	CHEW or designated health officer and WFP	Report (checklist) of supervisory visit	Quarterly to 50% of ward CHIPS on a rotational basis	LGA focal person (?RI FP)

Appendix IV: Commodities and Equipment Needed for the CHIPS Programme

Kit	Item
Pregnancy	Misoprostol- 600 µg/800 µg
Newborn care	Chlorhexidine Gel 25 g (4%)
Child Health	ORS-Zinc co-pack (under 5)
	Amoxicillin Dispersable- 250 mg tablet
	Rapid diagnostic test kits for malaria (under 5)
	ACT - 20 mg Artemether /120 mg Lumefantrine (6s & 12s)
	Long Lasting Insecticidal Net (LLIN)
	Respiratory Timers
Nutrition	MUAC Tape (Shakir)
	Anti-helminthics- 400g Albendazole/Mebendazole
First Aid	Plaster
	Gauze bandage
	Cotton wool
	Paracetamol tablets
	Iodine
	Gentian Violet
	Surgical Scissors
Kitting & Equipment	Latex disposable gloves
	CHIPS Branded Bag
	CEFP Branded Khaki Jacket
	CHIPS Branded Agent's Apron
	Andriod tablet for data collection
PPE	Hand Sanitiser
	Option 1 - CHIPS Branded Cloth face mask
	Option 2 - Disposable face mask

Appendix V: Procurement Process for CHIPS Commodities

The procurement process for CHIPS commodities are outlined below:

1. The quantification of commodities for the CHIPS Programme should be included in the health facility annual work plan.
2. SPHCDA work with NPHCDA to review the work plan and needs assessments for the CHIPS Programme.
3. SPHCDA conduct procurement process for manufacturers of health commodities using National Competitive Bidding process.
4. NPHCDA negotiates with manufacturers and suppliers of health commodities to ensure a reduction in costs and consistency in supply for the benefit of the states.
5. Manufacturers produce and package commodities into kits based on specifications and approved quantities.
6. Manufacturers supply packaged kits to States based on the agreed requisition.
7. States develop distribution plans and distribute kits directly to Health Facilities based on the plans.
8. Health facilities receive commodities from States and keep an inventory of the kits.
9. CHIPS Agents collect required commodities or tools weekly or as needed from the supervising CHEW or designated health officer upon showing proof of previous commodities utilisation.

Procurement Roles and Supervision

Procurements made by the state and LGA under this programme will be supervised as detailed in table 7 below. Supervisory visits will be conducted at least twice a year. The work plan and needs assessment are subject to NPHCDA's prior-review, while other procurement processes will be subject to post-review.

Table 7: Procurement Roles and Supervision

Level	Roles	Supervision
National	<ul style="list-style-type: none"> ● Provision of technical support to States for selection of commodity manufacturers ● Final approval of selected manufacturers by the Agency Tenders Board 	FMoH/NPHCDA/NSCIP
State	<ul style="list-style-type: none"> ● Conduct National Competitive Bidding process for the selection of commodity manufacturers using BPP Guidelines 	NPHCDA/PARTNERS/STATE LMCU
LGA	<ul style="list-style-type: none"> ● Optional (Based on work plan) 	SPHCDA/LGA LMCU

Appendix VI: Rewards and Sanctions

REWARDS

Rewards shall be given to the most outstanding CHIPS Agents in the Wards, LGAs, and States and the overall best Nationwide.

S/N	REWARD RECIPIENT	REWARD TYPE	REWARD FREQUENCY
1	Best CHIPS Agents at Ward level	The picture of the CHIPS Agent displayed on the notice board at the focal health facility	Monthly
2	Best CHIPS Agents at LGA level.	The CHIPS Agents shall receive a reward in cash or kind. (A name tag stating the award recognised for and the month(s) for which rewarded for)	Monthly or quarterly
3	Best CHIPS Agents in the best performing LGA at State level.	The CHIPS Agents shall receive a reward in cash or kind.	Bi-annually/Annually
4	Best CHIPS Agents, best-performing State, best CHEW or designated health officer, best State Focal Person, best performing LGA/Ward (Nationwide)	This shall be decided by NPHCDA	Annually

SANCTIONS

S/N	OFFENCE	DEFINITION	PUNISHMENT	ENFORCEMENT AUTHORITY
1	Falsification of records	Alteration of records or passing along copies of false documents to deceive another person	1 st -time offender - Warning and/or Suspension for a maximum of 3 months 2 nd time offender – Dismissal	WDC Disciplinary Committee or the State Disciplinary Committee The State Disciplinary Committee
2	Misappropriation of Funds	Intentional and illegal use of funds for an unauthorised purpose	Dismissal	The National / State Disciplinary Committee
3	Extortion	Demanding cash or kind before rendering service or sharing of free CHIPS commodities	1 st -time offender - Warning and/or Suspension for a maximum of 3 months 2 nd time offender – Dismissal	WDC Disciplinary Committee or the State Disciplinary Committee
4	Misuse of drugs/ drug abuse	This involves repackaging, prescription and wrong dispensing of the drugs. Also, the use of the drugs by the CHIPS Agents to the extent that he/she carries out his/her duties while intoxicated.	1 st -time offender - Suspension for a maximum of 3 months 2 nd time offender - Dismissal.	The LGA Disciplinary Committee shall handle the first-time offender. The 2 nd time offender shall be handled by the State Disciplinary Committee
5	Negligence	Negligence in carrying out his/her duty of care owed to the client to the extent that a client sustains an irreversible bodily injury like loss of a body part, serious disfigurement or death as a result of the CHIPS Agents' action, when the action of the CHIPS Agent that leads to such could have been avoided.	Dismissal. In the case of death, the CHIPS Agents shall be handed over to the appropriate authority for prosecution.	The State and National Disciplinary Committees

6	Prohibited Acts/Services	Administration of injections, examining pregnant women, taking deliveries, carrying out abortions, carrying out HIV/AIDS tests or any other thing outside their scope of work	<ul style="list-style-type: none"> If the client had a mild or no side effect from such act of the CHIPS Agent, there will be a suspension for the 1st-time offender and dismissal for the 2nd-time offender, however, for carrying out an abortion, there will be a dismissal. If the patient suffered a severe side effect, it is Dismissal In the case of death, the Agents shall be handed over to the appropriate authority. 	<ul style="list-style-type: none"> In the case of suspension, it shall be handled by the LGA Disciplinary Committee. In the case of dismissal, it shall be handled by the State Disciplinary Committee. In the case of death, it shall be handled by the National Disciplinary Committee
7	Breach of Patient Confidentiality	The disclosure of a patient's personal and medical information by the Agents without the patient's permission. And in the case of a minor, his parent, caregiver or legal guardian's permission	<p>1st-time offender</p> <p>- Suspension for a maximum of 3 months</p> <p>2nd time offender- Dismissal</p>	The LGA and State Disciplinary Committees
8	Criminal Offence	These include Theft, Rape, Murder, and any other act considered a criminal act by the Laws of the Federal Republic of Nigeria	Dismissal. The Agents shall be handed over to the appropriate authority for prosecution	The State and the National Disciplinary Committees.

Appendix VII: Mentoring and Supportive Supervision Levels of the Programme

	Activity	Target	Responsible Person	Level	Duration	Frequency
1.	Mentoring	CHIPS Agent	CHEW/OIC	Community	12 weeks	4 times a month
2.	Integrated Supportive Supervision (ISS)	LGA CHIPS Desk, CHIPS Focal Facilities, CHIPS Personnel	State ISS team	LGA, Ward and Community	Ongoing	Quarterly
3.	ISS	CHIPS Focal Facilities, CHIPS personnel	LGA ISS team	Ward and Community	Ongoing	Monthly
4.	ISS	CHIPS Personnel	Ward ISS team (CHEW/OIC)	Community	Ongoing	Monthly

Appendix VIII: Roles and Responsibilities of NPHCDA and States

Governance and Coordination

- Engagement Meetings
 - NPHCDA Roles and Responsibilities
 - SSOs liaise with state representatives to schedule 1st and 2nd engagement meetings
 - Share all pre-implementation presentations, documents and tools
 - Provide technical and programmatic support to the state PIU
 - SPHCDA Roles and Responsibilities
 - Engage with stakeholders
 - Appoint a CHIPS State Coordinator
 - Set up a PIU
 - Populate all CHIPS programme tools
- Adaptation/Adoption of Programme Guide
 - NPHCDA Roles and Responsibilities
 - Provide the standards of the programme
 - SPHCDA Roles and Responsibilities
 - Adapt the programme guide to state context, while upholding programme implementation standards
 - Ensure partners follow the recommendations from the programme guide for the implementation of the programme

Capacity Building

- Planning for Selection and Training
 - NPHCDA Roles and Responsibilities
 - Support States in planning for selection and training
 - Ensure proper quantification of training documents and materials.
 - Ensure all documents needed for the selection exercise are made available before commencement
 - SPHCDA Roles and Responsibilities
 - Ensure that the training venue is conducive
 - Ensure all materials required for the training and selection exercise are available in adequate numbers
- Engagement of Facilitators
 - NPHCDA Role and Responsibilities
 - Engage national facilitators
 - Ensure training ratios are maintained
 - Ensure the welfare of national facilitators are catered to
 - SPHCDA Role and Responsibilities
 - Engage State and LGA facilitators
 - Ensure training ratios are maintained

Monitoring and Evaluation

- **Baseline Assessments**
 - NPHCDA Roles and Responsibilities
 - Provide technical support to states for conducting baseline assessment before commencement of implementation phase
 - SPHCDA Roles and Responsibilities
 - Conduct baseline assessment for state and develop report for dissemination and use
- **Data Recording and Collection Tools**
 - NPHCDA Roles and Responsibilities
 - Develop and review the Programmes data recording and collection tools
 - Provide support to states on quantification of data tool requirements for training and service provision
 - Provide electronic versions of CHIPS Programme Data Recording and Collection tools to states
 - Provide guidance on data tool specification
 - SPHCDA Roles and Responsibilities
 - Conduct baseline assessment for state and develop report for dissemination and use
- **Knowing the Community**
 - NPHCDA Roles and Responsibilities
 - Provide guidance to states on how to plan for and conduct activity
 - SPHCDA Roles and Responsibilities
 - Conduct activity and report data generated
- **Programme Monitoring**
 - NPHCDA Roles and Responsibilities
 - Provide guidance on data collection, data reporting, supervision and programme review meetings
 - Develop and share tools and templates for monitoring the programme at sub-national levels to implementing states
 - Conduct supervision to programme states biannually
 - SPHCDA Roles and Responsibilities
 - Provide support to ward and LGA levels on data collection, data reporting, supervision and programme review meetings
 - Provide support to ward and LGA levels on data submission and reporting
 - Report programme data to the national using designated template
 - Conduct supervision as recommended in the programme guideline

Communication and Demand Generation

NPHCDA Roles and Responsibilities

- Coordinate all National level Communication and Demand Creation activities – Development of Communication Strategy/Plan, Development of Crisis Management Plan, Advocacy, Partners mapping, Stakeholders Engagement, Development of Advocacy kits and IEC materials, pre-test of the materials, production and dissemination of the materials

- Technical support to States in coordination of all Communication and Demand Creation activities – Adoption/adaptation of the Communication Strategy/Plan, adoption/adaptation of the Crisis Management Plan, Advocacy, Partners mapping, Stakeholders Engagement, adoption / adaptation of Advocacy kits and IEC materials, pre-test of the materials, production and dissemination of the materials etc.
- Monitoring / supervision of all Communication and Demand Creation activities at National, State LGA, Ward and Community level

SPHCDA Roles and Responsibilities

- Coordinate all State level Communication and Demand Creation activities – Adoption/adaptation of the Communication Strategy/Plan, adoption/adaptation of the Crisis Management Plan, Advocacy, Partners mapping, Stakeholders Engagement, adoption / adaptation of Advocacy kits and IEC materials, pre-test of the materials, production and dissemination of the materials etc.
- Technical support to LGA, Ward and Community in coordination of all Communication and Demand Creation activities – Adoption/adaptation of the Communication Plan, adoption/adaptation of the Crisis Management Plan, Advocacy, Stakeholders Engagement, dissemination of IEC materials etc.
- Monitoring / supervision of all Communication and Demand Creation activities at State LGA, Ward and Community level

Female Empowerment

- Stakeholder Engagement
 - NPHCDA Roles and Responsibilities
 - Engage stakeholders
 - Ensure partners working at the community level in the empowerment space engage the CHIPS personnel
 - SPHCDA Roles and Responsibilities.
 - Engage stakeholders
 - Ensure partners working at the community level in the empowerment space engage the CHIPS personnel
- Partner mapping
 - NPHCDA Roles and Responsibilities
 - Share partner mapping template with states
 - Follow up with states to engage partners identified in their States
 - SPHCDA Roles and Responsibilities
 - Complete the partner mapping template
 - Engage partners identified in your state
- Enrolling CHIPS Personnel into mass literacy programs
 - NPHCDA Roles and Responsibilities
 - Engage with NMEC for opportunities to support CHIPS Agents
 - Follow up with states to enroll the required CHIPS Agents into mass literacy programs
 - SPHCDA Roles and Responsibilities
 - Ensure CHIPS Agents with low or no literacy capacity are enrolled into the mass literacy program.

- Enroll CHIPS Personnel into Economic empowerment schemes
 - NPHCDA Roles and Responsibilities
 - Engage with partners to support CHIPS Personnel with skills acquisition and income generation activities
 - Support States to enroll CHIPS Personnel into the economic empowerment scheme
 - SPHCDA Roles and Responsibilities
 - Engage with partners to support CHIPS Personnel with skills acquisition and income generation activities.
 - Ensure CHIPS Personnel are enrolled into the economic empowerment scheme

Commodities and Logistics

- Quantification and Costing of CHIPS Commodities
 - NPHCDA Roles and Responsibilities
 - Assist to develop commodity quantification and cost tool
 - Support States in completing relevant tools
 - Support state to validate and ensure quantifications done by States based on agreed assumptions.
- Procurement of commodities
 - NPHCDA Roles and Responsibilities
 - Liaise with Procurement Unit in cases of central procurement
 - Support States to conduct procurement in case of State procurement
 - SPHCDA Roles and Responsibilities
 - Work/ liaise with procurement Department or division to make sure that all the CHIPS commodities approved by the management for procurement are been procured.
- Distribution from National to State Stores
 - Liaise with the officer in charge of store for effective and proper storage/ documentation
- Distribution from State to LGA/HF
 - Provide guidance to States for LMD based on work plan
- SPHCDA Roles and Responsibilities
 - He/she is to work with the head of store for receiving, proper storing and documentation of all the CHIPS commodities.
 - To ensure proper distribution plan/arrangement and inform/share with the receiving stores officer.
 - Be mindful of FIFO & FEFO commodities.
 - To ensure LMD
 - To ensure that where state procured, such commodities are supplied directly to the state warehouses before delivery to the HF
- Drawing a Distribution Plan
 - NPHCDA Roles and Responsibilities
 - The total quantity of procured commodities will determine the quantity of commodities that will go to each of the implementing States base on the number of projected population of implementing wards.

SPHCDA Roles and Responsibilities

- The total quantity of commodities procured will determine the quantity of commodities that will go to each of the LGAs base on the number of projected population of implementing wards.

Costing and Finance

- NPHCDA Roles and Responsibilities
 - Provide 5% BHCPF
 - Mobilize resources from stakeholders where applicable
 - Ensure stakeholders/partners uphold the standards of the programme
- State Responsibilities
 - Mobilize additional resources
 - Engage with stakeholders for funding support
 - Ensure stakeholders/partners uphold the standards of the programme
 - Sign MoU with partners

Appendix IX: Terms of References for Community Engagement Persons

Terms of Reference for CHIPS Community Engagement Persons

1. Work with CHIPS Agents to encourage male involvement in birth preparedness and development of a birth plan.
2. Address issues of non-compliance to ANC, Exclusive Breast Feeding (EBF), Routine Immunisation (RI) or facility delivery and unresolved forward issues to Ward Heads.
3. Provide support to CHIPS Agents in the conduct of their activities as well as special measures to address security challenges
4. Facilitate the tracking of community referrals where male involvement is required.
5. Form male support groups to discuss topics such as WASH, HIV, the importance of family planning, non-communicable diseases related to men (e.g., Prostate Cancer, Testicular Cancer, Heart diseases etc.) in collaboration with traditional and religious leaders.
6. Report to WDC and Supervising CHEW or designated health officer.
7. Supervise the CHIPS Agents to ensure the collection of good quality community data.
8. Collect community data from CHIPS Agents, upload to DHIS2 and submit hard copies to the PHC.
9. The CEFP will report notifiable diseases to the supervising CHEW or designated health officer who will then report appropriately [to Ward Focal Person (WFP), who will, in turn, report to the DSNO].
10. Should be well behaved and role models in their communities.
11. Communicate information on community outreach programmes and other health activities to the CHIPS Agents in the ward.
12. Conduct scheduled and random checks of CHIPS Agents activities at the household level.
13. Any other roles assigned to them.

