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MINISTRY OF HEALTH-ETHIOPIA

Primary Health Care Unit

Health Post Level Guidelines to Implement the Reaching Every District (RED) Strategy

Photo: Shehzad Noorani

June 2021

Implementing Reaching Every District/Community (RED/C):

A Practical Guide for the Health Post Level

Acknowledgements

Suggested Citation

Forward

The Federal Democratic Republic of Ethiopia, Ministry of Health recognizes the crucial role immunization plays in reducing child morbidity and mortality and it affirms its responsibility to ensure that every child is protected from vaccine preventable diseases. Expanded Program on Immunization (EPI), has built on the direction and planning of the Government's Health Sector Transformation Plan (HSTP), the Comprehensive Multi-Year Plan (cMYP 2021-2025), the Reach-Every-District (RED) immunization approach and other initiatives that flag quality and equity at the center of their agenda.

FMOH with its EPI partners has prepared this RED PHCU guide, driven from the RED guide which can be used during operation of routine immunization activity at health center and Health post level. This guide is aimed to strengthen immunization systems by improving planning, managing available resources, service delivery and monitoring, in the context of primary healthcare based on community needs at service delivery points.

This in turn improves equitable and sustainable access to vaccines for every age-eligible individual and reduces incidence of vaccine-preventable diseases (VPDs). This RED PHCU guide emphasizes five important areas for immunization programs: (1) reducing inequity in immunization coverage, (2) integration of health services, (3) delivering vaccines beyond infancy using a life course approach, (4) increasing urbanization, and (5) insecurity and conflict. Adherence to the contents of this guide will streamline efforts by all stakeholders to increase coverage upholding quality and equitable access to immunization by all communities.

The Ministry of Health appreciates the role of partner organizations and individuals in contributing technically and financially in the development and operationalization of the RED PHCU pocket guide.

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INTRODUCTION

Ethiopia has implemented the Reaching Every District (RED) approach to strengthen routine immunization (RI) services for over 15 years. In 2018, Ethiopia introduced an adapted version of the RED approach with guidance specific to implementation in Ethiopia. As a complement to the Ethiopian RED Guide, these guidelines provide staff in the primary health care unit (PHCU), which includes both health centers (HCs) and health post (HPs), with the essential information to carry out their RED implementation tasks. This specific guide is focused on implementation at the HP level.

As the focus of the RED approach is on strengthening district level service delivery, this guide is intended to provide step-by-step guidance for health workers to implement the five main operational components of RED: 1) planning and management of resources, 2) reaching all eligible populations, 3) engaging communities, 4) supportive supervision, and 5) monitoring and use of data for action. This guide provides detailed information on immunization activities that should be completed at the HP level on an annual, quarterly, or monthly basis, or after every immunization session, one time only, or as needed.

Who Is This Guide For?

- HP staff (nurses, HEWs)

How Is This Guide Organized?

- Overview of tasks for HP level
- Detailed description of tasks and tools for the HP level

How Should This Guide Be Used?

This document should serve as a reference guide for PHCUs for the management and delivery of immunization services. The HP guide provides information for health workers providing immunization services, who are mostly at the health post level. HC and HP staff should review the guide on a regular basis as a reminder of critical tasks and how frequently they should be carried out.

OVERVIEW OF RED TASKS AT HEALTH POSTS

Table 1. Actions for Health Extension Workers (HEWs) and Clinical Nurses

Every Year	Every Quarter	Every Month	Every Vaccination Session
Activity 1: Prepare a microplan for the health post.	**Activity 2**: Review and update the microplan. **Activity 3**: Mobilize community resources to support mobile and outreach sessions.	**Activity 4**: Submit complete and timely immunization data to the PHCU. **Activity 5**: Monitor static and outreach immunization sessions monthly and mobile services quarterly. **Activity 6**: Monitor immunization coverage and dropout rates and update the immunization monitoring chart. **Activity 7**: Provide your supervisor with the immunization data needed for supportive supervision visits. **Activity 8**: Participate activity during supportive supervision visits and carry out follow-up actions after each. **Activity 9**: Collaborate with the community to get updated information for each village. **Activity 10**: Convene monthly meetings of the Quality Improvement Team (QIT) and provide orientation to new members, as needed.	**Activity 11**: Review the session plan and schedule for static, outreach, and/or mobile services. **Activity 12**: Mobilize the community and prepare supplies for the immunization session. **Activity 13**: Record complete, accurate data for each immunization session. **Activity 14**: Provide QIT members or social mobilizers with a list of defaulters to bring to the next session.
One Time Only or As Needed			
Activity 15: Invite key community members to become members of QITs.			

DETAILED GUIDANCE FOR IMPLEMENTING GUIDANCE FOR IMPLEMENTING RED AT THE HEALTH POST LEVEL

At the health post level, health extension workers (HEWs) and clinical nurses should carry out the tasks described in this guide. The tasks are organized according to whether they are implemented every year, every quarter, every month, after each vaccination session, one time only, or as needed.

EVERY YEAR

There is one main RED activity for HEWs to carry out at the beginning of every year (i.e., Hamle).

Activity 1: Prepare a microplan for the health post.

Health posts should prepare a new microplan every year. The appropriate time for microplan preparation is Miazia or Ginbot.

Carry out the following microplanning tasks:

Miazia	**Task 1.** Coordinate with the PHCU to obtain the microplan tool and discuss updates to your plan with your PHCU supervisor.
	Task 2. Engage with community members to map the community and plan for service delivery.
	Task 3. Draft the microplan.
Ginbot	**Task 4.** Submit the draft microplan to PHCU/woreda supervisors for review and feedback.
Sene/Hamle	**Task 5.** Retain a copy of the revised microplan and share it with the community during QIT meetings.

Task 1. Coordinate with the PHCU to obtain the microplan tool and discuss updates to your plan with your PHCU supervisor.

Health post (HP) staff should discuss with their PHCU supervisor how to prepare a bottom-up microplan for their catchment population and area using the HP microplan template.

HP staff should prepare the following information for microplan development:

a. Sub-kebele targets (ideally through a head count of the community).

b. Previous quarter performance (e.g., coverage, dropout rate, sessions conducted, unimmunized children, hard-to reach villages).

c. Immunization challenges and local solutions identified to improve service delivery strategies (static, outreach, and mobile).

Task 2. Engage with community members to map the community and plan for service delivery.

When developing the microplan, community engagement is critical. Prior to the microplanning session, invite key community members such as kebele, clan, and religious leaders to participate in the session. The involvement of these stakeholders can:

a. Improve planning (e.g., community leaders can inform HP staff when and where services should take place).

b. Mobilize resources (e.g., woreda administrators may be able to allocate additional funding for immunization activities).

c. Promote ownership of the immunization program across the kebele. During microplanning, identify which stakeholder will support which activity and the type of resources needed.

Task 3. Draft the microplan.

a. **As you prepare to develop the microplan:**

   i. Determine how you will identify or estimate target populations using local means, such as head counts, data from pregnant women and newborn registrations, and child health days (CHD), and calculate supply needs for the coming year.

   ii. Use data about the target populations to develop a map illustrating the HP's catchment areas and populations and the strategies for reaching them (i.e., static, outreach, or mobile). (See b. below for more information about catchment area maps).

   iii. Design an immunization service delivery strategy that reaches all target populations with **all** routine immunizations as per the national schedule.

   iv. Define realistic local actions for improving and sustaining quality immunization coverage (e.g., open new outreach sites, conduct monthly meetings with the community).

b. **Draft an HP catchment area map.** Develop or update a catchment area/Expanded Program on Immunization (EPI) map by sketching the geography, boundaries, and important features of the catchment area.

Sample HP Catchment Area Map
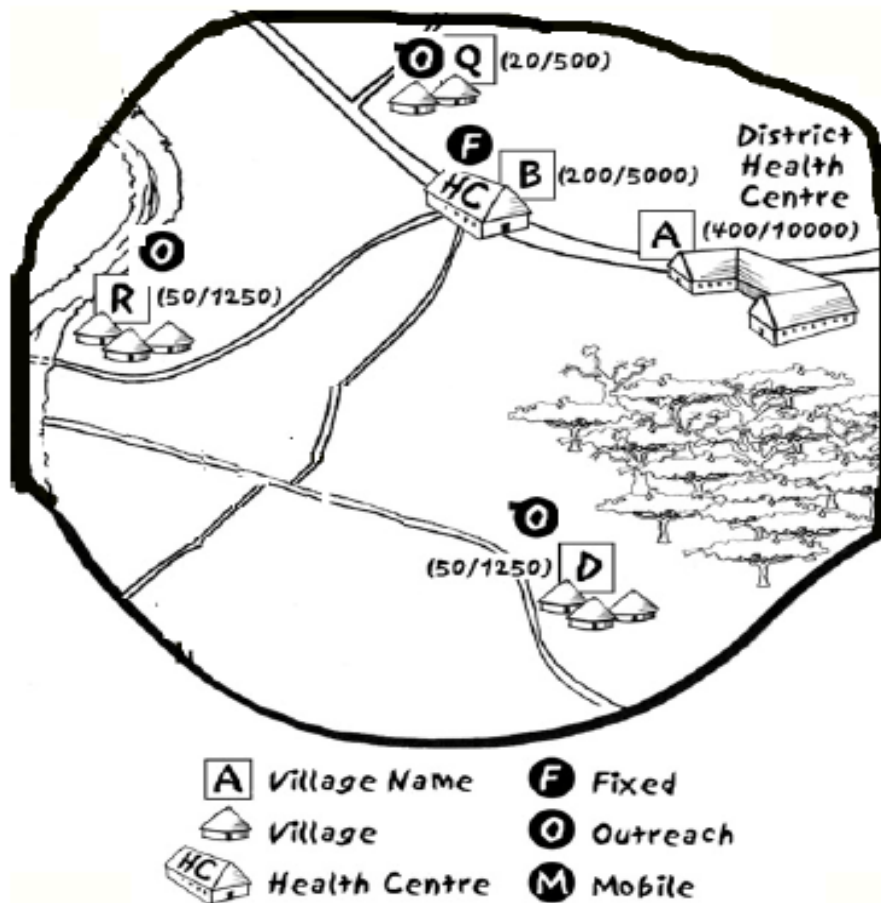
An HP catchment area map should include:

- o Villages and communities and their immunization service delivery sites and strategies (i.e., fixed, outreach, or mobile).

- o Important landmarks such as schools, government buildings, water points, churches and mosques, rivers, mountains, roads, transit and meeting points of pastoral communities, bus transport, and migration routes.

- o "High risk" or "hard-to-reach" communities.

- o Major climate and geographical barriers to service, such as seasonal flooding and impassable roads.

- o Distances and travel time between the communities and service delivery sites.

- o If possible, community seasonal travel routes.

c. **With community involvement, complete the microplan.** Work with community members and the QIT to estimate accurate eligible populations by sub-kebele. Determine the dates and locations of upcoming vaccination services. Then use the kebele/health post microplan form and steps described below to prepare the microplan (see Annex 1 for the HP microplan template).

    i. **Sub-kebele inventory form:** insert the target population using the head count[1] from each sub-kebele, distance between the sub-kebele or immunization site to the health facility, cold chain availability and functionality, means of transportation, and skills/training of HEWs and health workers. Engage community members in estimating the target population through a head count.

    ii. **Sub-kebele data analysis:** Analyze immunization coverage and drop-out data by sub-kebele and identify a RED category (Category 1-4) for each sub-kebele. Then categorize the kebele or health post based on sub-kebele categorizations. Using data from the previous planning cycle (the fiscal year or quarter), review the following for each sub-kebele:

- Immunization coverage by antigen.

- Dropout rates for Penta1-Penta 3; Penta1-measles-1; MCV1-MCV2.

- Number of sessions planned versus conducted.

- Factors affecting performance (good or poor) and challenges.

- Possible solutions to obstacles identified.

- Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis to identify reasons for successes and challenges.

    iii. **Sub-kebele session planning form:** Consult with the community to identify each sub-kebele and its target population. Determine the location of immunization sites (static, outreach, and mobile) that are near target populations, distance between the sites and the health post, the frequency and dates of sessions, and the community contact person and designated HEW/health worker.

- Identify with the community the date and location of each session.

  - List each sub-kebele and its target population.

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[1] The term "head count" refers to target population estimates obtained by measures other than calculations using a conversion factor. More accurate target population estimates may be obtained through a community census ("head counts"), or a combination of other data sources, such as pregnant women and newborn registrations, under two years registration, and immunization campaign data. Estimation methods may vary by area, as local areas use their own approaches and contexts to estimate target populations.

- Indicate the type of strategy to be used (fixed, outreach, or mobile) and the frequency of sessions. Plan for **at least four immunization sessions** for remote sites every year.

iv. **Health facility annual work plan form:** List the service delivery sites (static, outreach, and mobile) and the date for every site each month. This form is also used to monitor sessions planned versus conducted. Health post staff update/fill in the date of sessions conducted every month.

Tasks 4. Submit the draft microplan to PHCU/woreda supervisors for review and feedback.

Make sure to submit your draft microplan to the PHCU or woreda for review. They will review your plan to ensure feasibility and whether the planned activities have the resources and logistics needed for implementation, such as transportation and adequate human resources for outreach and mobile sessions. After the PHCU/woreda reviews the microplan, they will ask you to incorporate their feedback into the plan. Then you will update the microplan and submit the final copy to the PHCU/woreda.

Task 5. Retain a copy of the revised microplan and share it with the community during QIT meetings.

HPs should keep the final copy of their microplan and use it for monthly monitoring of service delivery—planned and conducted sessions for static, outreach, and mobile services. HP staff should also share the final microplan with community members during a QIT meeting to ensure that the community is aware of the plan and to gain their support for social mobilization and implementation monitoring.

EVERY QUARTER

There are two main RED activities for HEWs to carry out at the beginning of each quarter [July, October, January, and April].

Activity 2	Review and update the microplan.
Activity 3	Mobilize community resources to support mobile and outreach sessions, such as providing logistical support and guides.

Activity 2: Review and update the microplan.

Health posts should review and update their microplan at least every quarter. With help from community members and the QIT, update the catchment area map if there were changes in location of any villages, landmarks, or previously unreached areas, or any new migrant or displaced settlement sites. In addition, review the previous quarter's performance with community members or the QIT by carrying out the following tasks.

Task 1. Reflect on the delivery strategy for the HP (static, outreach and mobile services). Analyze how well the strategy is working (e.g. ability to carry out each session, how many children vaccinated each session, distances required to travel and frequency of sessions, and any challenges in reaching target populations).

Task 2. Compare sessions conducted with those planned and identify the reasons for interruptions (if any).

Task 3. Calculate coverage and the number of vaccinated and unvaccinated children.

Task 4. Review problems critically using Quality Improvement tools, such as a fishbone diagram (more information to follow), and divide big problems into smaller pieces to understand the root cause of the problem and develop local solutions.

Figure 1. Review and Update the Microplan

Review the delivery strategies (F, OR, and M) → Compare sessions conducted with those planned and identify the reasons for interruptions (if any) → Calculate coverage and the number of vaccinated and unvaccinated children → Review problems critically using Quality Improvement tools, such as a fishbone analysis

Use a Fishbone Diagram to Identify Root Causes and Effective Solutions

What it is: A fishbone diagram is a way to map out a problem's root causes. This enables teams to address the root cause rather than focusing on symptoms.

Why do it: To identify the sources (root causes) of a problem, which helps teams to develop lasting solutions.

Who should do it: A small, focused team (e.g., HEWs, nurses, EPI focal persons, and others who experience or are affected by the problem). Other possible team members:

- QIT members, including community leaders and members.

- Managers who have insight into the problem, a role in solving the problem, or facilitation skills to help move the process along.

How to do it:

1. Draft a clear **problem statement** that all team members agree to.

   Write the problem statement in the head of the "fish." Draw a line with an arrow toward the head—this is the fish's "backbone." In the example shown here, the problem is **low coverage**.

2. Brainstorm **major categories** of issues that might be part of the problem. Connect them to the backbone as "ribs." Common categories include the health system, geography, materials, policies, the environment, culture/tradition, methods, and information.
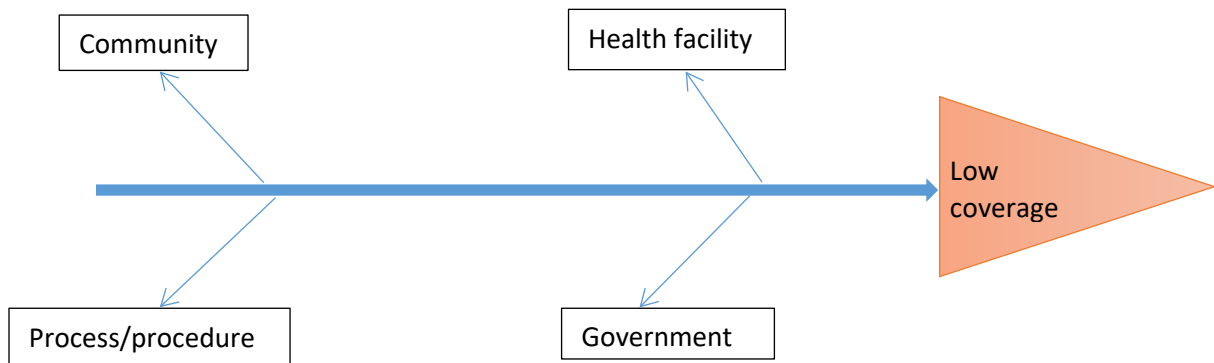
3. For each category, brainstorm **contributing factors** (i.e., possible causes of the problem). (Or choose one category where you know the group can act.) Attach each contributing factor to the appropriate rib (category). Some contributing factors may fit into multiple categories.
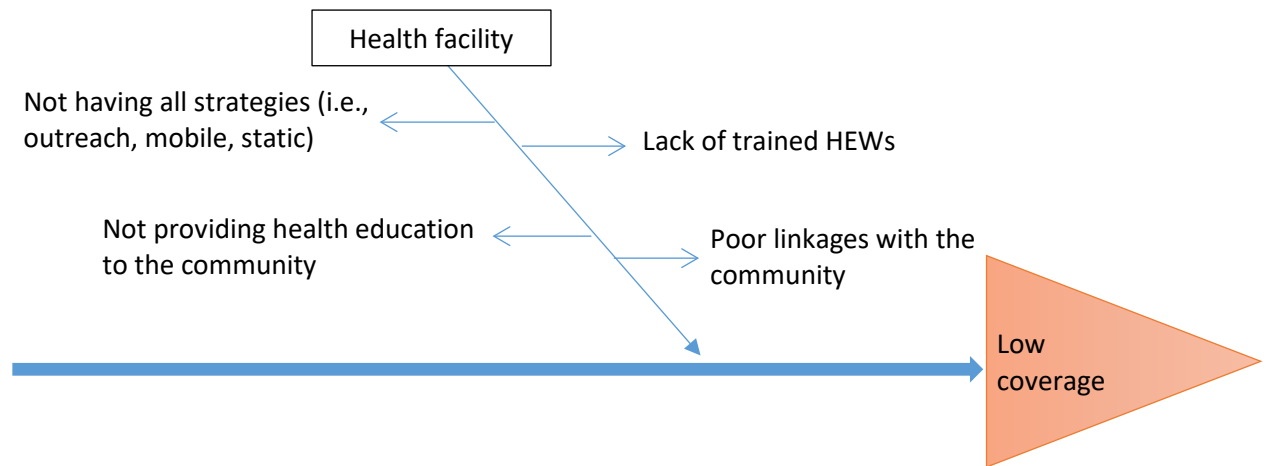
4. Push to identify **deeper causes.** You may end up with several branches on each successively smaller rib. Continue to go deeper for a clear understanding. **Ask "why" two to five times,** as in the example below.

5. Identify **main reasons/root causes** by looking for causes that appear more than once. Addressing the root cause can affect many contributing factors and have far-reaching effects.

    •   In the example below, "Health committee not informed about their role" seems to be a good root cause to address.

    •   Factors to consider regarding which main reason/root cause to address include:

        o   The likely impact of addressing that root cause (the greater the likely impact, the more important it is to address).

        o   How difficult it will be to address the root cause.

        o   The resources available to address the root cause.

        o   Whether there is a logical order in which to address the root causes.

    •   Finding an appropriate root cause to address may involve trial and error, as there may be multiple root causes to address.

    •   If the team decides to address a given root cause and the problem continues to occur, you have probably not identified the actual root cause.

    •   Take another look at the root causes and keep asking "Why?"

Health facility

Lack of trained HWs

Not having each strategy (i.e., outreach, mobile, static)

Health committee is not mobilizing

Health committee not informed about role

Poor linkages with the community

Not providing health education to community

No regular meetings of health committee

Health committee not informed about role

Low coverage
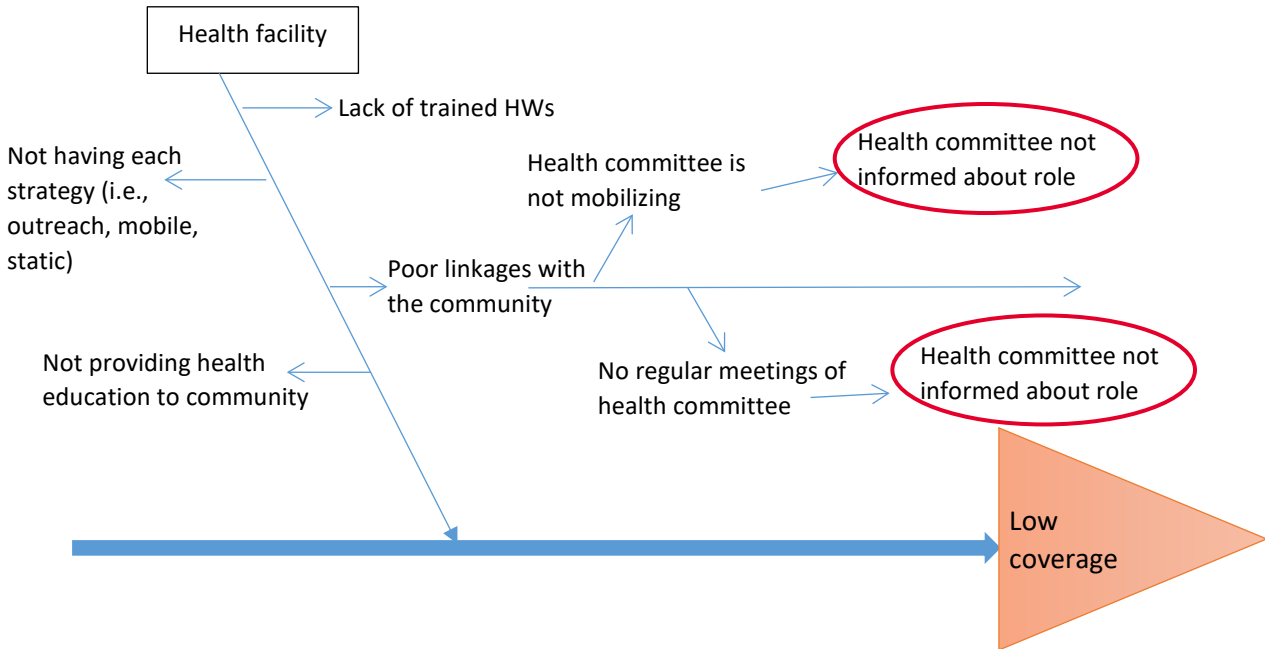
6. Develop and implement **local solutions** or try a different solution based on the identified root cause.

- Select local solutions that are within your control and could make the situation better.

- Test local solutions or try something else using the Plan-Do-Study-Act (PDSA) cycle.

Ask why to understand the root cause of a problem:

Problem
Low immunization coverage

Why?

Poor linkages to the community

Why?

Health committee is not mobilizing

Why?

Health committee is not informed about their role
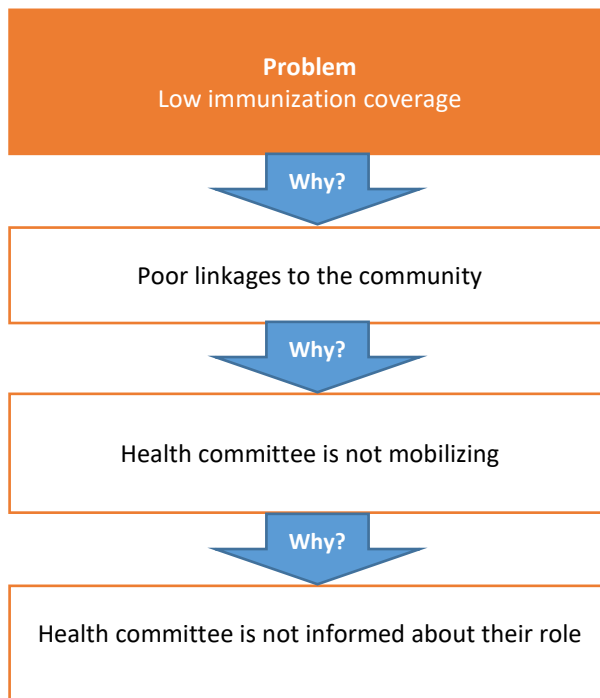
> **Discuss with your supervisor opportunities for integrated service delivery.**
>
> *As you plan for mobile and outreach service delivery, discuss with your supervisor what other activities it may be feasible to integrate with immunization services (for example, aligning "ready to use" food distribution with immunization sessions). Focus on activities that are likely to be manageable during immunization outreach/mobile sessions. If your HP is planning to implement mobile service delivery based on your microplan, review the guidance document: Practical Guide for Woredas to Implement Mobile Immunization Services for more information on how to set up and implement mobile services.*

Using the information you have gathered about delivery strategies, coverage, and problems associated with (and local solutions for) service delivery, fill out an HP microplan form (see Annex 1) and submit it to the PHCU/woreda, pointing out any resource gaps during implementation.

Activity 3: Mobilize community resources to support mobile and outreach sessions, such as providing logistical support and guides.

Work with the community to mobilize support for the following tasks:

Task 1. Register children under two and pregnant women.

Task 2. Identify children who did not receive any vaccinations (i.e., "left out") and defaulters.

Task 3. Support the transport of vaccines and logistics to outreach/mobile sites.

Task 4. Provide outreach or mobile teams with a community member to guide the teams to immunization sites and to link with the community.

EVERY MONTH

There are seven main RED activities for HEWs to carry out every month.

Activity 4	Submit complete and timely immunization data to the PHCU.
Activity 5	Monitor static and outreach immunization sessions monthly and mobile services quarterly.
Activity 6	Monitor immunization coverage and dropout rates and update the immunization monitoring chart.
Activity 7	Provide your supervisor with the immunization data needed for supportive supervision visits.
Activity 8	Participate actively during supportive supervision visits and carry out follow-up actions after each visit.
Activity 9	Collaborate with the community to get updated information on the number of pregnant women and newborns, the tracing of defaulters, and population movement patterns for each village.
Activity 10	Convene monthly meetings of the Quality Improvement Team and provide orientation to new members, as needed.

Activity 4: Submit complete and timely immunization data to the PHCU.

Compile data from immunization sessions (static, outreach, and mobile) from tally sheets or the registration book. Prepare and submit your monthly report on time each month to your supervisor. Every month, submit timely vaccine requests (using the Vaccine Request Form or mBrana) to the PHCU to avoid vaccine stockouts and session interruptions. Compile and submit the refrigerator temperature recording form and daily temperature records (if there is a refrigerator in the HP).

Activity 5: Monitor static and outreach immunization sessions monthly and mobile services quarterly.

Based on the microplan, HP staff are required to monitor static and outreach immunization sessions every month and mobile sessions every quarter using the health facility EPI work plan form and submit completed forms to the PHCU. If there were any session interruptions during the reporting period, discuss the possible reasons and potential solutions with the community and the PHCU.

Activity 6: Monitor immunization coverage and dropout rates and update the immunization monitoring chart.

For each village/gotte, use routine immunization data to analyze and summarize coverage and dropout rates, the number of unimmunized children, vaccine stockouts, and session interruptions. This will enable you to see overall immunization performance and whether any areas need support.

In calculating coverage and dropout rates, "doses administered" and "number of vaccinated children" are used interchangeably as the numerator.

Task 1: Calculate coverage for Penta1, Penta3, Measles 1, and Measles 2 for each village.

Coverage = The number of vaccinated children with an antigen divided by the target population and multiplied by 100.

Examples:

Calculating Penta 1 coverage: the number of children vaccinated with Penta1 divided by the target population and multiplied by 100.

Calculating Penta 3 coverage: the number of children vaccinated with Penta3 divided by the target population and multiplied by 100.

Calculating Measles 1 and 2 coverage: the number of children vaccinated with MCV1 (or MCV2) divided by the target population and multiplied by 100.

Task 2: Calculate the number of unimmunized children in each village.

Number of **unimmunized children**:
- for Penta1= the target population **minus the** number of children vaccinated with Penta1.
- for Penta3= the target population **minus the** number of children vaccinated with Penta3.
- for Measles1= the target population **minus the** number of children vaccinated with MCV1.
- for Measles 2= the target population **minus the** number of children vaccinated with MCV2.

Task 3: Calculate dropout rates for Penta 1 - Penta 3, Penta 1 - MCV1 and MCV1 - MCV2 for each village.

Dropout rate for Penta 1 - Penta 3: the number of children vaccinated with Penta 1 minus the number of children vaccinated with Penta 3 divided by the number of children vaccinated with Penta 1 multiplied by 100.

Dropout rate for Penta 1 - MCV1: the number of children vaccinated with Penta 1 minus the number of children vaccinated with MCV1 divided by the number of children vaccinated with Penta 1 multiplied by 100.

Dropout rate for MCV1 - MCV2: the number of children vaccinated with MCV1 minus the number of children vaccinated with MCV2 divided by the number of children vaccinated with MCV1 multiplied by 100.

Task 4: For low coverage and high dropout rates, identify the reasons and take corrective actions.

To address low coverage or high dropout rates (DOR), you need to understand the root cause of the problem. With community members and/or the QIT, carry out a root cause analysis using the fishbone diagram described earlier. Once you have identified the root causes with community members and/or the QIT, discuss possible solutions for each root cause and develop a plan to implement each selected solution.

When you see low coverage and/or high DORs, it is also a good idea to review the HP's microplan and strategies for service delivery.

To identify the reasons for low coverage and high dropouts, ask yourself the following questions:

i. Have we designed sessions to reach all target populations (i.e., through outreach and mobile sessions)?

ii. Are we implementing the planned services? (i.e., were all planned outreach and mobile services conducted)? If not, why not? Were there problems related to transport, staff shortages, or other issues?

iii. Were session dates and locations aligned with the routes of population movement, and were the dates and locations communicated?

iv. Is there a system for alerting community leaders to mobilize the community prior to an outreach or mobile session? Are there obstacles related to community awareness or engagement? Ask the QIT and/or community members what they think.

v. Are all recording and reporting tools in place? Are there issues related to data collection, analysis, or utilization? Check the correspondence between data in the tally sheet and the EPI registration book.

vi. Are all villages (gottes) covered and identified in the catchment area map? Talk with kebele or clan leaders to confirm that all communities are included in the map.

vii. Were there any shortages of vaccines or supplies?

Then design appropriate actions for the prioritized root causes of low coverage or high dropout rates and implement the actions.

Activity 7: Provide your supervisor with the immunization data needed for supportive supervision visits.

Health post staff should share key data on immunization performance with their supervisors so that it can be discussed during supportive supervision visits. During visits, share the following data and resources with your supervisor:

a. Monthly reports, tally sheets, the EPI register, and the EPI monitoring chart.

b. Sessions planned and sessions conducted.

c. Information on vaccines and dry supplies, the ledger book, temperature records, and mBrana/VRFs.

d. The QIT minute book with notes on problems and/or problem-solving efforts.

Activity 8: Participate actively during supportive supervision visits and carry out follow-up actions after each visit.

Supportive supervision is a learning and capacity-building opportunity for health workers, who should be attentive and actively engaged to benefit from the visit. The visit provides health workers with an opportunity for one-to-one discussion, knowledge transfer, skill building, experience sharing, and updates on tools, procedures, and standards. Make sure to discuss what is going well in the HP; use this as an opportunity to share your promising practices with your supervisor so s/he can identify ways to share best practices (i.e. during review meetings, through peer learning networks such as on what's app). The supervisor can help to identify gaps and factors involved in low performance and provide guidance on seeking local solutions and agreeing to follow-up actions.

Activity 9: Collaborate with the community to get updated information on the number of pregnant women and newborns, the tracing of defaulters, and population movement patterns for each village.

Task 1: Discuss the following issues with community members:

a. The importance of registering and regularly updating target population estimates (i.e., pregnant women, newborns, children under two) and sharing this information with the HEW/nurse.

b. The need to track population movement patterns and routes in pastoralist communities and provide this information to the HP for use in session planning and implementation.

c. Identifying a contact person in the community who will communicate regularly with HP staff.

Task 2: Make sure that your HP does the following:

a. Provides registration forms to the contact person in each community for registering and updating target population estimates and collects completed forms every month.

b. Provides each community contact person with a list of defaulters and encourages tracking them and bringing them to the next immunization session.

c. Makes sure that each contact person understands when and where the next vaccination session will take place and passes this information along to the community.

Activity 10: Convene monthly meetings of the Quality Improvement Team and provide orientation to new members, as needed.

Conduct monthly meetings with community members or the QIT to monitor immunization performance. The QIT identifies problems by reviewing data on issues such as coverage, dropouts, outreach and mobile sessions, and vaccine stock.

    a. Ensure that QIT members are actively engaged when the team uses tools such as the fishbone diagram or multiple "whys" to identify, prioritize, and solve problems.

    b. Develop action plans to address problems detailing what, who, and when. These plans should include monitoring progress using good data practices and documentation.

        i. Review the data and identify successes and challenges.

        ii. Compare the results with previous or baseline data to see whether improvements can be integrated into the existing practice or the plan needs to be modified.

        iii. Document all processes using the QIT minute book.

The Multiple Whys tool is another QI technique used to explore the root causes of a problem by asking why a problem exists in the first place. The answer to the first *why* forms the basis for subsequent *whys* and leads to digging deeper to identify the cause.

Consider the following example: The problem that has been identified is that children are defaulting on their follow-up immunization doses. Some of the *whys* and responses might be:

- *Why* are children not returning for their subsequent immunization doses?
  Answer: Parents do not know when to return for follow-up doses.

- *Why* do parents not know when to return?
  Answer: The health workers do not provide parents with the information and do not issue immunization cards.

- *Why* are the health workers not providing this information?
  Answer: They do not have the information or they forget to provide it.

- *Why* do the health workers not have the information or forget to provide it?
  Answer: They need supportive supervision to strengthen their skills.

EVERY VACCINATION SESSION

There are four main RED activities for HEWs to carry out for every vaccination session.

Before every vaccination session	**Activity 11.** Review the session plan and schedule for static, outreach and/or mobile services.
	Activity 12. Mobilize the community and prepare supplies for the immunization session.
During every session	**Activity 13.** Record complete, accurate data for each immunization session.
After every vaccination session	**Activity 14.** Provide QIT members or social mobilizers with a list of defaulters to bring to the next session.

Activity 11: Review the session plan and schedule for static, outreach, and/or mobile services.

Task 1. For static services:

    a. Confirm that the dates and times of the immunization services are as planned and do not conflict with holidays or public events.

    b. Make sure that the community is aware of schedule changes, including rescheduled sessions.

Task 2. For mobile and outreach sessions:

    a. **One week prior to the session,** review the session plan and begin organizing outreach or mobile services according to the microplan.

    b. Contact the community focal person (social mobilizer) and confirm the session date, time, place, and the number of children and women expected. Make sure that health workers have access to the mobile numbers of (or other means of contacting) key community leaders in the catchment areas.

    c. Request that a community member serve as a guide to support the vaccination team during outreach and mobile sessions.

    d. Find out where cold chain, vaccines, and supplies will be made available for the session.

        i. Records and reporting: EPI tally sheet(s); EPI register; information, education, and communication (IEC) materials/job aids; passport card; and defaulter tracing tool.

        ii. Materials: vaccines, auto-disable (AD) syringes, safety box, and mixing syringe.

Activity 12: Mobilize the community and prepare supplies for the immunization session.

Task 1. **One to two days prior to the immunization session:**

    a.   Ask community groups (e.g., community/religious leaders, social mobilizers, health development armies—HDAs) to mobilize families to bring children to the session.

Task 2. Finalize planning for cold chain/logistics.

    a.   Ensure that there is a vaccine carrier with a foam pad.

    b.   Prepare conditioned/chilled ice packs the night before the session.

    c.   Have a back-up plan in case a vaccine team has to be in the field longer than expected.

    d.   Check the vaccine vial monitors (VVMs) and expiration date before the antigens are put in the vaccine carrier for outreach/mobile sessions.

Task 3. Make sure that all EPI tools are available (e.g., registration book, tally sheet, passport card). Carry the EPI register to mobile and outreach sessions.

Activity 13: Record complete, accurate data for each immunization session.

Task 1. During every session: good quality data collection should begin at the immunization session.

    a.   During the registration of mothers and children, check whether they are new or returning.

    b.   After each administration of vaccines, complete the records in the vaccination registers, vaccination cards or health passports, and tally sheets.

    c.   Make sure that mothers and caretakers receive the essential immunization messages below.

Essential immunization messages

    1.   *The diseases that are prevented by the vaccines the child received today.*

    2.   *The possible side effects that could occur and how to manage them.*

    3.   *The number of visits the child needs to be fully immunized or protected.*

    4.   *The importance of not missing the next scheduled session, even if the child is sick.*

    5.   *The date, time, and place of the child's next immunization.*

    6. *Remind the mother to keep the vaccination card and bring it with her to future visits.*

Task 2. After each vaccination session:

    a.   Cross check the number of total doses given in the register with the tally sheets to make sure the numbers match.

    b.   If there is a mismatch, recount the number of doses of the antigen(s) given from the register and reconcile it with the tally sheet.

Activity 14: Provide QIT members or social mobilizers with a list of defaulters to bring to the next session.

    a.   Prepare a list of defaulters from the registration book or family folder.

    b.   Provide a copy of the defaulters list to QIT members.

    c.   Ask QIT members to contact the families on the list and tell the parents when and where the next session will be.

    d.   Ask QIT members to encourage parents to bring the child to the next session.

    e.   Make sure that the data on defaulters is included in the monthly report submitted to the PHCU/woreda.

ONE TIME ONLY OR AS NEEDED

Activity 15. Invite community members to become members of Quality Improvement Teams (QITs).

Task 1. Reactivate or establish QITs: Health workers at health posts should reactivate existing QITs and establish new ones to support immunization services. Reactivating existing QITs can vary, but it typically includes identifying command posts, a steering committee, a health or social mobilization committee, and a few influential persons to serve as additional members. QITs may vary in size, but 8-12 members is generally recommended.

Task 2. Provide orientation to new QIT members: describe their role and responsibilities, QI methods, and tools. The roles and responsibilities of QIT members include:

a. Collaborate with health workers to ensure implementation of RED.

b. Hold regular meetings to discuss routine immunization (RI) issues, analyze the root causes of problems, prioritize the causes, and develop solutions.

c. Share proposed actions with their sub-kebele/gotte for action (e.g., registration of pregnant women and newborns, defaulter tracing, and social mobilization for outreach and mobile sessions).

ANNEXES

Annex 1: Health post microplan template

Kebele Inventory																																Form K1
Region:						**Zone:**			**Wored**			**Kebele:**								**Date of Compilation:**													
Sub-Kebele Name	Total Population	Target Population								Sub-Kebele contact person	Distance from Kebele	Type		# Health Facility				# Functional EPI Sites				Transportation Access? (yes=1, No=0)			# Functional Cold chain Equipment			# staff trainined						Name of hard to reach area
		Live birth	Surviving infant	12-23 months	12-59 months	HPV target	Preg. Women	Non-Preg. Women			Rural	Urban	Hos	HC	HP	Total	Fixed	OR	Mobile	Total	Car	Motor Bike	Animal /walk	Refrig	Cold box	V. Carrier	IIP	IRT	Cold Chain	Vaccine Management	Injection Safety	Other	
Total																																	

NB:

Use annaul conversion factor for each target population (Live birth, surviving infant, etc)

e.g. Live birth= Totap pop * annual conversion factor of the region

Name of coordinator: _____   **Signature:** _____

Sub-Kebele Session planning																

Date filled in: _____ Region: _____ Woreda: _____ Health Facility: _____ **Form K2**

Name of the site (fixed, outreach mobile) for service	Target Population per year							Distance or time to vaccination post (km or	# injections per year	Other key MNCH activities for integration (e.g. Vit, de-worming,	Session type	Sessions			Responsible Person	
	Live birth	SI	12-23 months	12-59 months	HPV target	PW	NPW				F, OR & M	#per year	#per month	Day of Session	HEW/HW	sub-Kebele Mobile #
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q

*How to calculate # of injection per Year: Static: 40 injections per vaccination/day and for outreach/mobile session: 30 injections per vaccination/day

* If other services are integrated such as VAS, consider for statice session: 35 injections per vaccination/day and for outreach/mobile session: 25 injections per vaccination/day

#injections/year= # children* # total injection (a child should take 10 injections to fully immunized and 2 Td injections for PW= 12 injections). Hence # injections/year = # children *12

injection/month= #injection per /12

sesions/year for static= # injection per year/40

sesions/year for OR/M= # injection per year/30

sesions/month for static= # sesions/year for static/12

sesions/month OR= # sesions/year for OR/12

sesions/quarter for M= # sesions/year for OR or M/4

Sub Kebele Data Analysis Summary form																									Data of_____			Form K3
Region:			**Zone:**					**Woreda:**							**Kebele**														

																					Analyse problem							
Sub Kebele Name					**Doses of vaccine administered**							**Immunization Coverage (%)**						**Unimmunized (No.)**						**Drop-out rates**		**Identify & categorize Problems**				
	Total Pop	**Surviving Infant**	**12-23 Months**	**HPV target**	**Penta1**	**Penta3**	**MCV1**	**MCV2**	**HPV**	**Td2+**		**Penta1**	**Penta3**	**MCV1**	**MCV2**	**HPV**	**Td2+**	**Penta3**	**MCV1**	**MCV2**	**HPV**	**Td2+**	**P1-P3**	**MCV1-MCV2**	**Access**	**Utiliztion**	**Category; 1,2,3,4**	**Are there significant # VPDs?**	**Are there significant # of high irsk pop?**	**Are there significant # of unimmunized ?**	**Priority/rank (1,,2,3,4)**
	a	b	c	d	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	ab	ac	ad	ae	af	ag	ah
Total																														

Category

1 = No problem,; drop-out rates low(<5%) or (<10%), coverage (access) high (DPT1 > 90% or >80%) based on regional context

2 = Utilization Problem; drop-out rates high, coverage (access) high.

3 = Access Problem; drop-out rates low, coverage (access) low.

4 = Both Access and Utilization Problem; drop-out rates high, coverage (access) low.

Priority

Category 4=Priority 1

Category 3=Priority 2

Category 2=Priority 3

Category 1=Priority 4

Annual RI workplan															
Region/Zone: _____ Woreda: _____ Health Facility: _____									Form K4						
Name of service delivery site	Session plan (F, OR, M)		Hamle	Nehase	Meskerem	Tikmit	Hidar	Tahisas	Tir	Yekatit	Megabit	Miazia	Gginbot	Sene
	Static	Date scheduled												
		Date held												
	Outreach 1	Date scheduled												
		Date held												
	Outreach 2	Date scheduled												
		Date held												
	Outreach 3	Date scheduled												
		Date held												
	Mobie 1	Date scheduled												
		Date held												
	Mobile 2	Date scheduled												
		Date held												
	Mobile 3	Date scheduled												
		Date held												
Grand Total		Total planned in the month												
		Total held in the month												

Annex 2: HP SS checklist

Routine Immunization Supportive Supervision and Self- Assessment Checklist- Health Post			
Woreda Name		Under which PHCUs	
Date of Visit		Name of HPs	
Total Population		Number of Kebeles	
Name of a Supervisor who completed this form		Number of sub-kebeles/kushet/tabia/Gotte	
		Any other (specify)	

#	Question	Yes, No or N/A	Comments
	Section 1A: Catchment Area and Management		
1	**Does the HP have a catchment area map showing sub-kebele boundaries, total population by sub-kebele, main roads/rivers, Mosques/Churches, schools and current static, outreach and mobile sites?** **YES**: If there is a map showing sub-kebele boundaries, total population by sub-kebele, main roads/rivers, Mosques/Churches, schools and current static, outreach and mobile sites **NO**: If there is no map posted or it does not include items indicated.		
2	**Is the current year's target population of pregnant women and surviving infants in the catchment area posted on the wall?** **YES**: If the current year's target population is posted on the wall in a visible place **NO**: If the target population for the current year is not posted on the wall in a visible place		
3	**Is there a current Session Plan of static, outreach and mobile vaccination sessions available -for the kebele (by sub-kebele, name of location of service, and schedule)?** **YES**: if there is an up-to-date session plan for all RI activities in the kebele (by sub-kebele) that shows location of service and schedule **NO**: If there is no RI session plan (static, outreach, mobile) by sub-kebele, location, and schedule.		

4	**Was the Session Plan for the previous month implemented?**		
	Note 1: If the answer to Question 3 was "NO," mark this question as NA (not applicable) and move to the next section (Section 1b)		
	Note 2: if the answer to Question 3 was "YES," review documents (registration book, tally sheets, and reports) and compare immunization session dates with the planned sessions on the Session Plan. **YES**: if all static, outreach and/or mobile sessions were conducted last month as scheduled on the session plan **NO:** if not all static, outreach and/or mobile sessions were conducted last month as scheduled or if there is no current session plan posted.		
**Section 1B: Microplanning**		
5	**Does the Health Post (HP) have a copy of the RI Microplan (MP) from the PHCU/Woreda for the current year?** **YES**: If the current RI Microplan (MP) document is available **NO**: If the MP for the current year is not available		
6	**Does the HP plan its sessions (static, outreach, mobile) based on the MP?** *Note: compare the Microplan with the Session Plan (#3 above)* **YES**: If the number of sessions indicated on the Session Plan are the same or more than the number of sessions planned in the Microplan **NO**: If the sessions shown on the Session Plan are less than the sessions planned in the Microplan		
**Section 1C: Community Involvement**		
7	**Is the QIT <u>or any other committee</u> involved in any of the following?** 1) Newborn registration 2) Community announcements for immunization sessions 3) Community education on immunization 4) Provides logistic support to the HF *Note: there must be documentation to support "yes" answers (e.g. minutes from meetings, newborn registration list)* **YES**: if at least 1 of the above are provided by the QIT/other committee and it is documented **NO**: if there is no documented involvement by the community		

8	**Is there a mechanism in place to track left-outs and/or defaulters?** *Note: use of 1-to-5 network, Women Development Army, other community structure, tickler file etc. Verify with documentation e.g. defaulter lists, newborn list, minutes of meetings discussing defaulters/left-outs)* **YES:** If health workers have any documented approach for tracking **No:** If there is no system for tracking left-outs or defaulters		

Section 1D: Data quality, management, and use			

9	**Are all antigens given recorded in the RI register with a date AND when a child is checked as fully immunized has the child or family folder received all antigens/doses as indicated by dates?** *Note: check the RI register to see that all entries are by dates and whether the register has dates across all antigens/doses for a fully-immunized child* **YES:** If all doses are registered with dates and all antigens/doses are given and recorded with dates for a fully immunized child **NO:** If dates are not always used or not all antigens/doses are recorded for a child indicated as fully immunized		

10. **Record the number of doses administered <u>for the previous month</u> for the following tools and antigens.**
If data for a certain tool is incomplete or if a tool is not available, write N/A in the box.

	Tally sheets (All from prev month)	EPI Register/ tickler file	Monitoring Chart	HP Monthly report
Penta1				
Penta3				
Measles 1 (MCV1)				

11	Is there a cumulative coverage & dropout (EPI) monitoring chart, correct and up-to-date to the previous month? *Note: check the correctness of the chart up to the previous month and compare data on the chart with data in the EPI register and monthly report* **YES**: If the monitoring chart is available and cumulative coverage and DOR are correctly calculated and plotted on the monitoring chart up to the previous month and if the data matches the data in the register and monthly report **NO**: If the monitoring chart is not updated, or if calculations/plotting are incorrect, or if the data does not match the register and report **NA:** If there is no EPI monitoring chart at all		
12	Can the Health worker adequately explain the meaning & use of the monitoring chart? *Note: Ask this question only if the EPI monitoring chart is available* **NA:** if EPI monitoring chart is not available **YES:if health worker can adequately explain the meaning & use of the monitoring chart** **NO: if health worker cannot adequately explain the meaning & use of the monitoring chart** *If no, explain to the health worker how to interpret the information displayed on the chart. Discuss issues of access and utilization.*		

Section 2: Vaccine Management (complete this section if the Health Post has a refrigerator)		
[if there is no fridge or fridge is non-functional, mark N/A for #13-20 and move to next section]		
13	Has the HP had a continuous supply of vaccines during the last 3 months? **YES:** in the last 3 months the HP did not have any stock out of any vaccine **NO**: in the last 3 months the HP had stockouts of one or more vaccines		
14	**Can you please show the document where the information on vaccine stock out is recorded?** **YES:** if vaccine stock out information from previous 3 months is documented **NO:** if there is no documentation to record when a stock out occurs		

15	If there was a stockout in the past 3 months, please fill in details in table below. If there was no stockout, write N/A.		
	Vaccine(s) that experienced stockout in past 3 months		
	How many days stocked out		
	Reason for stock out		
16	**Is the refrigerator temperature monitoring sheet filled in twice daily, including weekends and action taken during alarm time?** YES: If the recorded data in the temperature monitoring sheet is filled twice daily for the current month (up to date) and action taken during alarm time documented properly. NO: If the temperature monitoring sheet is **not** filled out correctly		
17	**Are all antigens correctly arranged in the appropriate compartment of the refrigerator?** YES: If each antigen and vials are stored in their proper place. NO: If there are antigens/vials improperly placed in the refrigerator		
18	**Do all vaccine vials have readable labels, are not expired, and all are in VVM stage 1or 2?** YES: if all vials have readable labels, are not expired and are in VVM stage 1 or 2. NO: if any vial has an unreadable label, is expired or is in VVM stage 3 or 4.		
19	**Does the health worker discard opened vials of BCG, Measles and PCV immediately after a session (or within six hours of opening/reconstitution)?** YES: the health worker discards opened vials of BCG, Measles, and PCV (confirm there are no open vials of BCG, measles, or PCV in the refrigerator) NO: if there are opened BCG, Measles or PCV vials in the refrigerator		
20	**Does the health worker label the date of opening for all open vials of OPV, TT, and IPV vaccines that are stored in the refrigerator?** YES: there are dates labelled for <u>all</u> open vials of OPV, TT, and IPV stored in the refrigerator NO: if any open vial of either OPV, TT, or IPV is missing a date labelling when it was opened NO OPEN VIALS: there are no opened vials of OPV, TT, or IPV currently in the refrigerator		
	Section 3: RED-QI quality improvement activities		

21	**Does the HP have a Quality Improvement Team (QIT) that uses QI tools to solve problems in health programs?** *Note: probe to ask what tools they use (e.g. may be fishbone, PDSA cycles, etc). If yes, check members name from minute book or other sources* **YES**: if the HP has a group that uses QI tools to solve health problems, and members names are documented **NO**: if there is no group that uses QI tools to solve problems in health programs. **If no, then mark N/A for 22-24**		
22	**Did the QIT conduct planned meetings in the last month with immunization as an agenda item?** **YES:** If there are minutes of the QIT meeting for <u>last month</u> and if immunization was one of the agenda items. **NO**: If there is no documentation of the meetings in the last month, the meeting was not held, OR if the content of the meetings does not include immunization. **N/A:** there is no group that uses QI tools to solve problems in health programs		Write the date of meeting conducted
23	**Does the QIT use data for improving RI service provision?** **YES:** if there is any RI data recorded in the minute book for last month's QIT meeting. **NO**: If there is no RI data recorded in the minute book for last month's meeting or there was no QIT meeting last month. **N/A:** there is no group that uses QI tools to solve problems in health programs		
24	**Does the team follow RED-QI/PDSA process and document it in the minute book?** **YES:** If the minute book has recorded minutes for the previous month that relate to conducting the PDSA process **NO:** if there is no recorded minutes from the previous month that relate to conducting the PDSA process **N/A:** there is no group that uses QI tools to solve problems in health programs		
**Section 4: Vaccination Session (complete this section if vaccination session is in progress)** **[if not, mark N/A for #25-28 and move to section 5]**		
25	**Is the vaccine carrier and vaccine correctly managed in the place where the session is conducted?** **YES**: if a foam pad is in use, there is chilled/ conditioned icepacks, there is no exposure of the vaccine carrier to direct sunlight, vaccine has readable labels, vaccine is not expired and all VVM are in Stage 1 or 2. **NO**: If any one of the above points is not fulfilled		

26	**Does the health worker (HW) give the 5 key messages to the caregiver?** *Observe the service provider giving these 5 key messages to caregiver:* *1. What disease do the vaccines prevent (which her child received today).* *2. Number of visits the client still needs in order to be fully immunized or protected.* *3. What side effects may occur and how they can be treated.* *4. Date, time and place of next immunization (writes the date of next visit on the card).* *5. Remind a mother to keep the card and bring it with her.* **YES:** if the service provider gives all 5 key messages to the caregiver **NO:** if even one of the five messages is not given		
27	**Were the "5 R's" implemented at the immunization session?** *(right client, right antigen, right time, right route, and right dose)* **YES**: if the Health Worker (HW) followed the "five rights" when giving the vaccine. **No**: if the HW missed (started to miss) even one of the five rights. **Supervisor should intervene appropriately before any potential harm occurs*		
28	**Are used syringes/needles placed immediately after the injection into the safety box without recapping?** **YES**: if the HW does not recap and uses the safety box immediately. **NO**: if the HW recaps the syringe/needle or **does not** place the syringe/needle immediately in the safety box after vaccination		
	Section 5: immunization wastage management		
29	**Are all used syringes and needles completely burned and in the incinerator or down in a pit?** **YES:** if all used syringes/needles are burned <u>and</u> inside the incinerator or down in a burn pit **NO:** if any used syringes/needles are not burned and/or not in the incinerator or pit		

Summary:

Copy the totals from each of the above sections and calculate overall percentage:

TOTALS	# of Questions	# of Applicable Questions	# of YES Answers	Percent (%) YES # of yes answers/ # of applicable questions
Section 1A. Catchment Area & Management (#1-4)	4			
Section 1B. Microplanning (#5-6)	2			
Section 1C. Community Involvement (#7-8)	2			
Section 1D. Data quality, management, and use (#9,11-12)	3			
Section 2. Vaccine Management (#13-20)	7			
Section 3. RED-QI Quality Improvement (#21-24)	4			
Section 4. Vaccination Session (#25-28)	4			
Section 5. immunization waste management (#29)	1			
GRAND TOTAL – all sections (do not include #10 in scoring)	**27**			

Data quality/consistency review: Describe what actions you took based on your review of the data in question #10.

3 Main Successes: highlight examples of specific areas/practices done well by the Woreda, and the reason why

<div style="border:1px solid black;">

1.

2.

3.

</div>

Action Table: Issues to be addressed

Sn	Issue	Action to be taken	Responsible Person	By when

Name and title of supervisor: _____ Sign/date: _____

Name and title of supervisor: _____ Sign/date: _____

Name and title of supervisee: _____ Sign/date: _____

Name and title of supervisee: _____ Sign/date: _____

Annex 3: Health Committee/ QIT Minute book

<div align="right">

Date: _____

</div>

1**. List of Members**

      1. _____
      2. _____
      3. _____
      4. _____
      5. _____

2. List of Prioritized problems

      a. _____
      b. _____
      c. _____
      d. _____
      e. _____

3. Select one problem _____

4. Objective [aim you wish to achieve/target you wish to achieve]

5. **Main reasons why do the selected problem occur**

      ➢

      ➢

      ➢

6. Proposed Activities/solution to address those main reasons

      ➢

      ➢

7. **Action Plan**

S.no	Activities	Responsible person	Date	Place
1.				
2.				
3.				

Data to be collected _____

Next meeting date: _____

8. Implement the **Action Plan** - Write what happened and write what you observed when you do the planned activities_____
_____

9. **Review** what happened after action plan implemented (Compare collected data with aim/objective to determine whether the measures were met, any challenge or lesson learned/success)
_____
_____

10. Next plan (Decision)
_____

Annex 4: Deliver safe immunization services during COVID-19 (IPC)

Update planning for immunization

In the event that COVID-19 pandemic prevail and the response effort is ongoing, it is important to review and update your microplan and adjust planning and conducting immunization sessions. It is particularly important to take a closer look in to the following:

1. Continue to maintain the target population by reviewing and updating list of children/mothers who need vaccination.

2. Update your session plans to compensate for missed delivery services.

3. If it is required, plan to increase frequency of sessions and decrease number of clients at each immunizations session.

Safety and protection of health workers and the community

1. Select a well ventilated area where you can ensure one-way flow and physical distance.

2. Avoid crowding and maintain a safe distance, at least a meter, in waiting areas and limit one adult per child for infant immunizations.

3. When possible make hand sanitizer or a hand washing facility available at the entrance of the health facility.

4. Perform screening of persons presenting respiratory symptoms before admission to the vaccination posts.

When conducting immunization sessions, the HW must:

1. Ensure the vaccinator wears a face mask, gloves on and use hand sanitizer as appropriate.

2. Plan outreach sessions not to exceed 15 people at a time. Scheduling additional sessions or time-slots may be needed.

3. Ensure HWs and beneficiaries/caregivers are strictly following the social distancing rules.

4. Ensure caregivers with flu like symptoms, fever or cough, or shortness of breath are referred to the health facility for investigation.

5. Ensure no child is returned unvaccinated for fear of vaccine wastage. Follow the guidance on open vial policy.

What should I communicate to communities about COVID-19 and routine immunization?

Communicate with families on the importance of immunization services to prevent serious childhood diseases. Explain to parents and caregivers precautionary measures are being taken to make the immunization session site safe for both health workers and clients. As possible, after each vaccination session provide information to the community on the following:

- Use a multi-layered cloth mask when going outside the house.

- Wash hands with soap properly before having meals, after coming back home from outside, after meeting with someone or accidently touching your mouth, nose and eyes.

- Do not touch your mouth, eyes and nose unnecessarily.

- Do not spit in public places.

- Unless essential, discourage visitors in the house.

- Consume a balanced and healthy diet, rich in immunity boosting foods, especially if you are pregnant.

- Regularly exercise for physical and mental immunity, especially if you are pregnant.

- Do not panic if you notice flu like symptoms. Contact the health authorities and seek their guidance.

- Follow proper social distancing guidelines, with a minimum of one meter distance from each other.