Technical sheets for polio eradication

This document was developed with the idea to synthesize and disseminate good practices and lessons learned from experience in many countries in the fields of supplementary immunization against polio, case investigations and AFP surveillance review.

The document is not meant to be exhaustive, but rather to provide simple technical sheets with basic key information on a variety of topics. The topics selected play a critical role in polio eradication. For more comprehensive guidelines we refer to: http://www.polioeradication.org/reports.asp

The objective of this document is:

- To synthesize and disseminate experiences from many countries and documents in simple, easily read sheets.
- To provide simple training materials;
- To provide a common understanding of best practices even though specific regional circumstances may cause differences in implementation.

17 September 2010

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I. Coordination structure for SIA

This document is part of a series of technical sheets to be used for the preparation and implementation of quality SIA, surveillance reviews or case investigations for polio. The series of sheets consists of the following:

I - Coordination	IV - Supervision	VII - Cold chain, VVM	X - Quality indicators
I I - Micro planning	V - House marking	VIII - Social mobilization	XI - WPV Case investigation
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Objective: To ensure all necessary steps in a campaign are taken in a timely, well coordinated and transparent manner.

Setting up a coordination structure, comprising of the following elements, should be the first step in SIA prerparations:

- Immediate formation of a Task Force/Steering Committee at all levels, state and (sub) district with representatives of the partners (MOH, WHO, UNICEF, Rotary, religious leaders, minority groups and other key partners).
- This Task Force should assign smaller technical subcommittees to deal with logistics, social mobilization, fund raising, etc..
- Ensuring proper information sharing, orally as well as by sharing minutes of meetings, between the subcommittees themselves and with the Task Force is critical.
- Regular scheduled meetings should be held:
  - on a monthly basis, or when required to deal with specific problems, the Task Force should meet to discuss the general outline of the campaign, work plan, key responsibilities, progress in the preparations, major obstacles and contingency plans.
  - a weekly meeting of the subcommittees to ensure smooth operational preparations.
  - the weekly meeting of subcommittees turns into a daily meeting during the last 2 weeks before the SIA. This meeting should not take more than 20 minutes, but is critical to streamline the final preparations
  - each meeting should function on basis of a number of standard procedures: simple agenda, minutes, action points from previous meetings, progress, problems encountered, proposed solutions, new action points with responsibilities and deadlines.
- Operations rooms with clearly visible and updated work plan and maps adapted to the specific level:
  - at state level the maps should indicate key surveillance data, SIA and EPI routine indicators, itineraries for vaccine distribution, districts with specific risks, places requiring cross border co-ordination.
  - at district level the maps should indicate the occurrence of wild polio cases, key surveillance data, SIA and EPI routine indicators, itineraries for vaccine distribution, areas with specific high risks, places requiring cross border co-ordination, areas with unclear delimitation.
  - at health centre level the maps should display the occurrence of wild polio cases, specific risk groups, distances, vaccine distribution points, transit points for travellers (bus- and railway stations, airports, police checkpoints, entry and exit points of main roads), other relevant land marks (mosques, churches, schools, markets, etc.), transport itineraries of supervisors and teams and target areas for supervisors and teams
- Specific work plans for each level, state, district and health centre, which clearly define persons, tasks, responsibilities and deadlines at the various levels. The plans need to be continuously updated and shared with partners.

Example of work plan:

Activity	**Deadline**	**In charge**	9/9	16/9	23/9	30/9	7/10
Prepare micro plan	9 Sept	Peter					
Send sheets to printer	16 Sept	Paul					
Distribute vaccine to regions	3 Oct	Mary					

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II. Micro planning

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Objective: To ensure the campaign activities reach all children. Micro plans lay out all operational aspects of an SIA at district and lower levels. It is the translation of the national macro plan to local constraints.

Requirements for successful micro planning include:

- Delegation of planning responsibility to the appropriate administrative level (e.g., sub district or health centre) where the activities will take place. Include the supervisors in the planning!
- The national standards (number of children/team/day, fuel consumption of vehicles, daily mileage for vehicle users, etc.) should serve as guides, rather than prescriptions, and be adapted to local constraints. The adapted plans should be communicated to the higher levels and help finalize the budget.
- Meetings should be held with village leaders (councillors in urban areas), and influential members of society to gain insights into what will work best as well as involve these people in the planning itself and selection of a member of their community as a team member.
- Meetings should also be held with other ministries, NGOs, associations, private companies, educational institutions and any other sector that might be able to give support to the campaign in terms of money, means of transportation, cold chain, staff, knowledge, etc.
- Plans should be based on local conditions, accessibility, geography, population movements, working hours (when are people at home?) culture, etc. in the catchment area.
- Micro plans must pay particular attention to special groups mentioned below and in the risk areas.
- Micro plans must include epidemiology based social mobilization activities.

Micro plans need to include details on: numbers of teams, supervisors, cars, boats, etc.; areas to be covered by day per supervisor and teams; special areas like bus and train stations, markets, schools, brick kilns, border crossings; special events like feasts, religious events, etc.; information on accessibility per season; contacts with community members, NGOs, associations, private companies, etc..

Evaluations in many countries show that the same population groups are missed by the routine programme as well as by supplemental immunization campaigns.

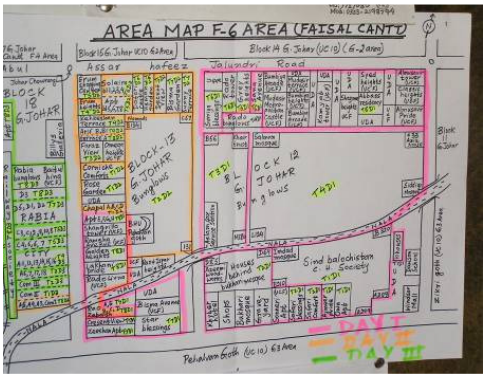
Missed populations should no be equated with remote populations. Everywhere people are missed, because the target population is underestimated and health staff targets a certain number of children rather than a geographic area. The following are examples of populations liable to be missed and requiring special attention:

- religious or ethnic minority groups, who may be generally underserved and suspicious (see the TS on social mobilization)
- difficult to reach populations like nomads, boat people, but also urban slum dwellers, etc.
- travellers, who may be on the road or in the train when the campaign takes place
- people with working hours that do not coincide with the team visits (agricultural seasons)
- people living in houses between settlements (the “no man’s land”)
- people that have lost their faith in the health programme, because of low quality of services provided, lack of explanation, and/or rude behaviour of vaccinators or supervisors
- people of specific socio economic status, that take a special effort to reach.

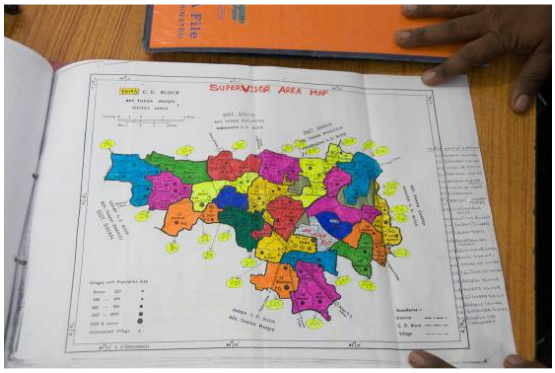
Critical steps in micro planning:

- Start with making a work plan at (sub) district level laying out clearly the activities that need to take place with deadlines and responsibilities (see the sheet on Coordination).
- Set up a coordination structure in terms of persons, responsibilities, meeting schedule and operations room.

- Obtain maps from the area and indicate distances, population spread, landmarks, borders, population movements, seasonal particularities (floods, etc.). Maps can be simple road maps or can be provided by veterinary services, ministries, etc..
- Obtain a list of potentially useful ministries (defence, transport, demography, political and religious influentials, NGOs, and other useful organizations. Contact them for contributions like means of transport, staff, cold chain, etc.. Ensure that all are regularly involved, or, to prevent over loading of meetings, at least informed of major developments, in particular if their services are requested.
- Calculate the target population at the level of the lowest planning unit using preferably experience from previous campaigns, monitoring data, data from routine immunization, or census data.
- Using the national guidelines on the number of children to be immunized per team and per day, calculate the approximate number of house to house teams, supervisors, number and types of means of transport in urban, semi-urban and rural settings. Use these numbers as guidance only and adapt them to the local realities.
- Select supervisory staff, review the numbers of the previous point and develop team's itineraries with them.
- Decide on special teams in bus/train stations, markets, feasts and other places where people gather or pass.
- Present the plans with the maps to community leaders and local health officials to discuss and adapt them to the reality. Pay special attention to contentious or unclear areas, areas with difficult access, special local events, seasonal activities, and risk groups mentioned previously. Ensure full understanding and buy-in by local community leaders.
- For the selection of the vaccination teams, ensure they are acceptable in terms of gender, age, religion and other locally specific requirements. At least one team member should always come from the area to be vaccinated.
- Teams' itineraries should be finalized by supervisors together with the teams during the training.
- Names of team members and supervisors should appear in the micro plan.
- Micro plans should be updated before each round to ensure integration of past experience, monitoring data, changing conditions in relation to the seasons (migration, flooding, sowing and harvesting), etc..



Team map in Pakistan



Supervisory map in India

Micro plans at all levels need to be accompanied by maps of various nature. See the TS IX about Mapping.

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III. Mapping

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Objective: At all levels of planning and implementation - national, regional, district, supervisors and vaccination team - maps are a critical tool to ensure children are not missed. They allow visualizing specific characteristics of an area, like topography, population spread, health and transport infrastructure, ethnic and religious grouping, accessibility, etc.

Children are too often missed, because planning is done without maps on basis of a mistakenly presumed common understanding of an area or on basis of inadequate or outdated maps.

Maps should be regularly updated to reflect the reality most adequately, including new construction, population movements, nomads, seasonal activities, reviewed administrative borders, etc..

Types of maps:

- state and regional level maps should indicate the occurrence of wild polio, key surveillance data, SIA and EPI indicators, itineraries for vaccine distribution, areas with specific risks, population density and spread, ethnic and religious minorities, contentious areas, places requiring cross border co-ordination.
- district or health centre level the maps should display:
  - the occurrence of wild polio cases,
  - settlements, nomads, migratory or seasonal populations and specific risk groups (ethnic, religious),
  - distances, vaccine distribution points,
  - transit points like bus- and railway stations, police checkpoints, toll stations, with the location of transit teams,
  - relevant land marks and special sites (mosques, churches, markets, schools, brick kilns, etc.)
  - supervisory areas, with as delimitation not be a mere line on the map, but a physical entity, like a road or river.
- maps for supervisors, made by them with the district health staff, should show the supervisory area in detail:
  - major landmarks, roads, rivers, villages, isolated settlements, special sites (schools, brick kilns, etc.), district and national borders and anything that can help clarify the understanding of the terrain and prevent missing children, houses or settlements.
  - team areas per day. Areas for successive days of the same team should as much as possible border each other. The delimitation of the areas should not be a simple line on the map, but a physical entity, like a road, river or anything else easily recognisable and known by the teams.
  - supervisors of transit teams should have maps clearly indicating the location of these teams.
- maps for vaccination teams should be made together with supervisors during the training and updated before each round. A walk of supervisors and teams through the area helps finalizing the details. These maps should show:
  - the catchment area for the day and the itinerary to be followed. The delimitation of the area as well as the start point of one team and the end point of the other should be clear. These should be physical entities, like a road or river rather than left to the team. Teams should know which teams work across the limits of their catchment area,
  - special sites (schools, brick kilns, etc.).
  - in cities and large villages maps should show the streets and major landmarks.
  - maps for rural teams should show their itinerary with special attention to houses or hamlets between the villages, temporary settlements, settlements with identical names or on borders between districts or health centre areas.

Sources of maps:

- hand drawn maps, in particular for supervisors and vaccination teams;
- hand drawn or photographic maps taken from an aeroplane;
- maps provided by MOH, ministries of transport or infrastructure, army, veterinary services, NGOs, UN organizations
- normal regular road maps
- satellite maps to be obtained from Google, or other sources.

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IV. Supervision of a house to house campaign

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Objective: to ensure that all children under 5 receive a dose of OPV of the right type and that all areas and houses are visited, including isolated communities, slums, top floors and any area teams may have difficulty or do not like to go.

The quality of the work of vaccination teams is the reflection of the quality of supervision. There is no point tackling the first without tackling the second.

- Choice of supervisors:
  - Supervisors should be chosen solely on basis of competence, independancy and respectability towards the teams as well as the community in terms gender, ethic or religious group, age
  - Supervisors should preferably live in the area they are supervising
  - Special supervisors should be assigned for teams on markets, bus/train stations, etc.
  - Badly performing supervisors should be replaced immediately
  - Recommended is 1 supervisor for 4-5 teams in urban and for 2-3 teams in rural areas
- Before beginning the house-to-house delivery of OPV, supervisors should:
  - Be properly trained by dedicated and competent staff and participate in the training of the vaccinators;
  - Walk or drive through the areas where their vaccination teams will be working and develop a reasonable daily itinerary with each team;
  - Agree with teams on contingency plans and on when to revisit houses again if children are absent;
  - With maps, clarify areas with unclear delimitations, villages with identical names and other contentious issues;
  - Assist in mobilizing the community, identifying village councillors, and other officials who can assist
- During house to house vaccination supervisors must ensure that:
  - Most important: gaps are identified, problems solved, and the strategy revised as necessary
  - Supervisory checklists are used. These lists should be simple, action-oriented, and 1 page maximum
  - Equipment and vaccine are distributed and given to the teams timely and in the correct quantities
  - Each team is visited at least once a day, during which the tally sheet is signed and the time of visit added
  - All children <5 years receive two drops of OPV of the right type (tri- or monovalent 1 or 3) and all areas and houses are visited, paying in particular attention to areas teams may have difficulty or do not like to go
  - Houses and children are correctly marked
  - All teams know how to interpret the VVM to ensure delivered OPV is potent
  - Tally sheets are completed immediately after each household visit
  - Teams are replenished in case they run out of vaccine, markers, chalk, etc.
  - Cases of refusal are dealt with and reported to the health authorities
  - Progress and problems are communicated to the local health authorities
  - Vaccination teams return to houses where children were missed
  - Supervisors for teams on markets, bus/train stations, etc., should ensure these areas are correctly selected and teams are clearly visible, actively searching for unimmunised children, entering buses and trains and present during the whole period people pass through, i.e. 24 hours per day in case of big bus stations
  - Spot checks (convenience sample surveys) are done to determine areas in which children are being missed.
  - Logistics and supplies are prepared for the next days work
  - Results are collected and reviewed with teams and the MOH at the end of each day
- After the campaign:
  - A report is prepared to summarize the activities and suggest improvements for the next day/round.
  - Additional training is provided to the teams not performing well. Team members are replaced as necessary.
  - Supervisor's debriefing with the MOH should take place on a daily basis and lead to corrective action.

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V. House marking

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Objective: House marking during house to house campaigns for polio eradication serves to facilitate for teams, supervisors, monitors and evaluators to know whether or not a household was visited, all children were immunized or needs to be revisited.

- General rules:
  - The definition of household may vary per country from the smallest family unit, to the persons sharing the same kitchen. It can include temporary settlements, boat people, or nomads moving around on camels. A too rigid definition may be counter productive.
  - Each household should be marked.
  - In compounds where several household share the same entrance, each household as well as the main entrance should be marked.
  - House marking should be done with cray, or any other locally accepted product, but never with ink markers.
  - The mark should be placed on, beside or above the door. If not possible, any other immobile object (rock, tree, fence, etc.) should be chosen. The location of the mark should preferably be protected from rain fall.
- The minimum information contained in the house marks should be:
  - Household number
  - Team number
  - Date
  - Whether all children were vaccinated or the household needs to be revisited.
- Additional information proven useful and doable in a number of countries and depending on local circumstances:
  - The status of the household: locked, refusal, long term absentee, etc;
  - the date and time the household was visited by the supervisor;
  - the number of children immunized ad the total number of children in the household
  - the date the household was revisited by the team to immunize missing children;
  - an indicator for the number of children immunized / number of children in the household
  - the direction the team is moving

Examples of simple basic house marking

T15 **H23**

29/6

Interpretation: Team 15 **V**isited (the V) household number 23 on 29 June and immunized all children (the circle), or there are no children.

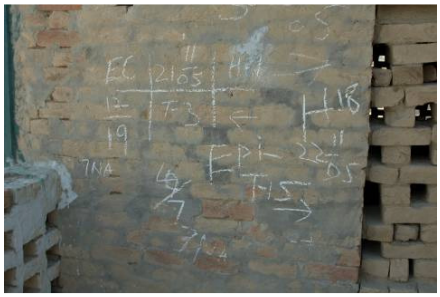
T18 **H74**

V

29/6

Interpretation: Team 18 **V**isited (the V) household number 74 on 29 June, but some children were missed and the household needs to be revisited (no circle). The team puts the circle only after all children are immunized.

Example of simple marking



Example of complex marking

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VI. Finger Marking

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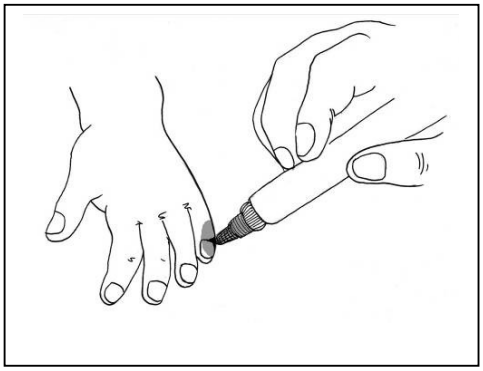
Objective: Finger marking during SIA allows teams, supervisors, monitors and evaluators to know whether or not a child has actually been immunized.

Marking should preferably be done with indelible ink markers, rather than gentian violet or other products, which usually do not stay visible long enough.

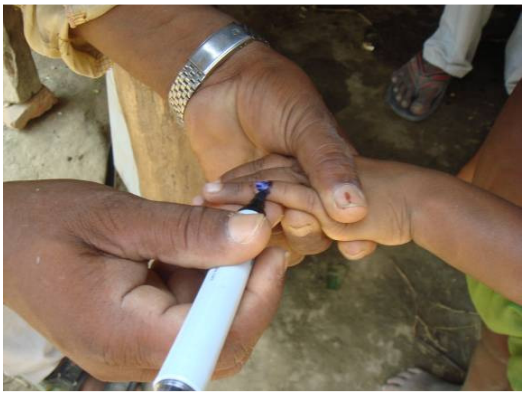
Finger marks done the correct way and with quality markers, stored and handled appropriately, will normally remain visible for the duration of the campaign and a few days after.

For effective and efficient use of finger markers, it is important that the teams should strictly follow the recommended methodology for finger marking.

- Ordering and Storage
  - The number of markers ordered should be 2 per team, or 1 per 250 children targeted;
  - To prevent the risk of drying out, markers should be ordered per round, or for 2 rounds if air conditioned storage is possible;
  - Markers should be stored in a cool, preferably air conditioned room;
  - Preferably new markers should be used for each round;
  - Reuse of left over markers from the previous round, that were never issued to teams, should only be considered if tests show they are still of good quality. The ones that were issued to teams should not be used again.
- Finger marking process:
  - Finger should be marked after administering of OPV and not before;
  - Before marking, the team should properly clean the child's nail using a piece of cloth/cotton;
  - Child's left little finger –not forehead, chin or ear etc - should be marked;
  - Application of ink on the nail and nail bed rather than skin of finger back;
  - Allow 30 seconds for the ink to dry.



- Handling finger marker:
  - Shake the marker gently before use;
  - Recap the marker immediately after use;
  - Proper re-capping by pressing on cap till hearing 'click' sound;
  - Keep the marker in a horizontal position after use;
  - Each team should have 2 markers;
  - Finger markers should never be used for other purposes e.g. door marking;
  - If finger markers are lost or not working, the team should immediately notify the supervisor to get another marker;
  - All teams should hand over the finger markers (used and unused) to the supervisor after finishing SIA activities.



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VII. Vaccine handling, cold chain and VVM

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Objective: to ensure potent OPV is given to the children.

Facts about Oral Polio Vaccine:

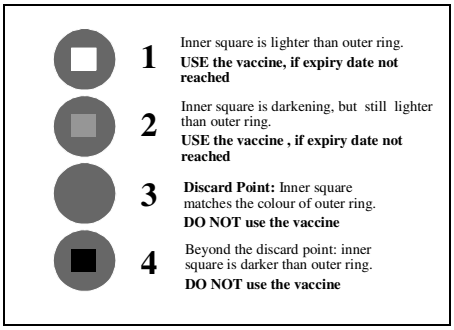
- OPV is the most heat sensitive of all EPI vaccines.
- There are currently 4 types of OPV, trivalent , bivalent and monovalent OPV 1 and 3;
- OPV exists in vials of 10 or 20 doses. The last ones are primarily used during SIA.
- OPV should be kept frozen in central and regional stores.
- Repeated freezing and thawing of OPV does not harm the vaccine;
- Once the vaccine is thawed, it can be used until the VVM reaches the discard point, or the expiry date is reached, whichever comes first;
- OPV is normally red, but some vials may be yellow. This does not affect the potency.

The Vaccine Vial Monitor (VVM)

The VVM allows monitoring cumulative heat exposure of a vaccine vial. It consists of a heat sensitive square within a circle (figure 2) that changes colour under the combined influence of heat and time. If after exposure to heat for a certain amount of time, the square reaches the same colour, or becomes darker than the circle, the vial should be discarded (stage 3-4).

The VVM indicates heat exposure and not overall quality of the vaccine. Vials that are otherwise faulty should be discarded irrespective the status of the VVM.

Figure 2: The stages of the VVM



OPV, supplied by WHO accredited manufacturers, retains satisfactory potency for at least 48 hours at an ambient temperature of 37°C. The VVM reaches at 37°C the discard point in less than 48 hours, to ensure a safety margin.

At lower temperatures the loss of potency is slowed down and the time taken for the VVM to reach the discard point increases substantially.

The VVM allows the user to see at any time if OPV can still be used in spite of cold chain interruptions. This allows for a more flexible vaccine handling, including the possibility to safely use vaccine beyond the cold chain, depending on ambient temperatures and the quality of the cold chain until that point.

The sole absence of ice ceases to be a reason to interrupt vaccination activities.

The advantages of the use of VVMs during SIA are:

- teams can go further in time and distance, due to less bulky equipment and decreased dependence on re-supply of icepacks;
- difficult access and weak cold chain cease to be reasons not to immunize population groups usually missed during SIA and routine services;
- teams can split up and enter buses and trains individually without a vaccine carrier, while keeping an eye on the VVM
- teams do not always require a vaccine carrier with the full load of icepacks. No or a single icepack may be enough, especially in ambient temperatures below 20-25°C and if the teams returns the vaccine in the evening to the stock. When taking this decision the acceptability by health staff and public must be part of the considerations.
- because fewer icepacks are required, freezing can be faster and with less equipment
- health worker and stock manager can decide which vials to use first or in nearby areas on the basis of the status of the VVM

It is strongly recommended regional and district health staff actually tries the VVM in their areas to get an idea of how flexible the cold chain can be in a given ambient temperature.

General vaccine handling instructions for vaccinators:

- Protect the carrier and OPV vials from sunlight.
- Open only one vial at a time and keep it outside the carrier.
- Icepacks are preferable, but if ice is used, vials should be wrapped in plastic, to prevent them from floating in the water and labels detaching.
- Open the lid of the carrier only after finishing the previous vial to take out another vial.
- Use only vaccine with the VVM in stage 1 and 2.
- Partially used vials can be used again the following day (Multiple dose vial policy), provided the VVM is in stage 1 or 2, the label is still attached to the vial and the vial is not otherwise faulty.

Monovalent OPV (mOPV)

- Storage and handling of mOPV and bOPV are the same as for trivalent OPV.
- To prevent unintentional use of tOPV during the campaign or mOPV/bOPV during the routine immunization ensure stocks are rigorously separated and differentiate mOPV/bOPV from tOPV in stock registers

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VIII. Social mobilization & advocacy

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Objectives:

- >95% of parents/caregivers aware of the campaign and demand immunization
- Strong Government visibility and commitment at the national, provincial levels, district and community levels;
- Involvement of religious, social and civic partners in polio immunization activities at all levels
- Identifying underserved populations or communities and intensifying efforts to reach them;

Planning for social mobilization – formation of social mobilization committees

It is critical that the Provincial/local social mobilization committees are functioning and start planning two weeks ahead of the campaign, as part of the overall micro-planning and mapping for the SIA. At each level (Provincial, district, sub-district) a work plan with objectives, activities, budget and responsible persons should be prepared. All strategies and activities should be underpinned by collected data that should highlight local challenges that social mobilization efforts should address.

The plan developed by the social mobilization committee should answer the following questions:

- What are the social mobilization issues for the particular province, district, sub-district level
- Who are the key target audiences that need to be reached?
- What information or messages need to be given to these groups?
- Who should be involved and how do we involve them?
- What are the available and most effective channels of communication?
- What activities should be planned to reach the key target audiences?
- What should be the roles of the various actors?
- What will it cost?
- What resources do we have available and what resources do we need (financial, human, other)?
- How will the impact of planned activities be evaluated?

The social mobilization committee should also consider other important issues such as:

- Who are the hard to reach populations?
- Are there likely to be any resistant groups?
- At the district and sub-district level, is the social mobilization committee ensuring the use of communication target and social mapping?

Budgeting for social mobilization activities

The budget may include the following: -

- Cost of briefing meetings for leaders and community groups
- Training and incentives for local mobilizers and town/vehicle announcers
- Cost of informational and promotional materials, posters, banners, megaphones etc
- Cost of producing radio and TV spots, jingles
- Cost of transportation for social mobilization activities
- Cost of launching activities

The social mobilization budget should be reflected in the overall plan. Any social mobilization funds need to be disbursed early so that social mobilization activities can be conducted in good time ahead of the immunization days. Nevertheless, local activities should not wait for funds from elsewhere. Resources should be mobilized at all levels to support feasible activities.

Social Mobilization Activities before and during the Campaign

When making initial contact with individuals and groups, request ideas and suggest specific ways in which they could participate such as:

- Announcing the campaign at key meetings, religious and traditional festivals, naming ceremonies as well as all other cultural and sporting events.
- Providing human, financial and other resources to develop social mobilization materials such as banners, T-shirts, leaflets and posters.
- Providing cold boxes or equipment, making ice packs necessary for keeping an effective cold chain system??? Why is this a social mobilization activity???
- Mobilizing their subjects and assigning some of their advisers and elders to help during the campaign
- Providing free air time for dissemination and broadcasting of messages
- Allowing safe passage and/or accommodation in areas of insecurity
- Endorsing and sponsoring radio and television announcements

Prepare materials in advance and distribute them on time!

- Posters, brochures, media spots, letters, T-shirts, posters and street banners should be designed, prepared, ordered and distributed in advance of the campaign.

Social mobilization 'must dos'

- Hold social mobilization committee planning meetings to clearly identify roles and responsibilities for the group
- Develop social mobilization plan and budget
- Meet with leaders of major religions and religious sects and traditional groups at the provincial/district level
- Hold meetings with key influential leaders (including politicians) to seek their support and endorsement
- Record (audio and video) key statements/ messages of support for distribution to communities
- Ensure all schools, churches and mosques are involved—letters and advocacy to all schools churches and mosques in the area
- Advocate with radio stations to include polio/immunization issues in health related programming, radio dramas, panel discussions
- Develop and distribute press release to all media outlets - about the polio campaign.
- Air jingles and spot announcements & air endorsements/statements of support from opinion leaders
- Launch ceremony at all levels involving key leaders
- Develop media spots and messages for the local context.
- Reproduce jingles, spot announcements for distribution to local community radio/TV stations. Plan to air endorsements before, during and after the polio campaign. It is important to have ongoing messages about the campaigns and routine immunization. Ensure endorsements through media, mosque and vehicles before and during campaign

Intensify Social Mobilization efforts in Under-served Areas

One of the key elements for successful campaigns is to reach un-immunized children. Since rural areas, nomadic and minority communities are sometimes difficult to mobilize to a vaccination post due to distances and changing locations, social mobilization efforts and micro planning should be particularly strong in these areas. However, under-served populations living in densely populated urban areas must not be forgotten.

Social mobilization efforts should prioritize under served areas.

Efforts should be tailored to reach under served populations, particularly minority groups or marginalized populations and religious communities that may resist public health interventions.

Such efforts might include.

- The social mobilization committee could hold preliminary meetings with opinion leaders of those communities. It is critical to ensure local community ownership and participation.
- These meetings should be followed by intense house-to-house visits by local volunteers from the same minority group.
- Working closely with leaders of the minority communities.
- Ensuring that members of the group who speak the same language are working at the immunization post.

Technical sheets for polio eradication

IX. Monitoring

This document is part of a series of technical sheets to be used for the preparation and implementation of quality SIA, surveillance reviews or case investigations for polio. The series of sheets consists of the following:

I - Coordination	IV - Supervision	VII - Cold chain, VVM	X - Quality indicators
I I - Micro planning	V - House marking	VIII - Social mobilization	XI - WPV Case investigation
III - Mapping	VI - Finger marking	IX - Monitoring	XII - AFP Surveillance review

Objective: Monitoring is critical for the evaluation of SIA and the timely detection of area specific problems. It should be conducted during (in-process) as well as after (end-process) the campaign, and be household as well as child based.

Monitoring is different from a coverage survey: it is primarily aimed at finding problem areas, rather than getting average coverage figures.

The fewer the indicators to monitor, the more likely they are to be looked at and used for action.

- Choice of monitors:
  - Monitors should be independent from the MOH and selected and trained by WHO;
  - Monitoring staff can consist of medical students, NGOs, teachers or anybody who can read and write, do simple arithmetics, be mobile, and communicate with health officials;
  - Monitoring staff should not be assigned to the same area for more than 3 rounds.
  - The number of monitors should allow getting a sample of about 1-2% of the target population or households.
- In-process (household) monitoring (see the Monitoring guideline included in this CD):
  - Each monitor should visit 4 clusters of 7 households per day, i.e. at least 28 children, and target rural as well as urban areas;
  - Selection of the area to be monitored should be done by WHO in collaboration with MOH staff. The area should be a risk area because of wild virus, geographical risk factors, past performance, feedback or other reasons;
  - In areas covered by the vaccination teams, monitors should focus on unmarked (missed) households and households where the house marking indicates that it does not need to be revisited by the teams, because all children in the household were vaccinated, long term absentees, no children or permanently locked.
  - Choice of the first household in the selected area should be more or less at random, for example by throwing a stick in the air in the centre of the village to decide on the direction to go;
  - After the first household every fifth (or other number to be decided) household should be visited, with the condition that during in-process monitoring, monitors skip households marked for revisit by the teams;
- End-process monitoring:
  - All households should be visited, irrespective their marks, using the same process as mentioned above;
  - Increasingly important becomes child based monitoring in bus and train terminals, markets and other places where people gather, by checking between 50 and 120 children for finger marking.
- Minimum indicators to monitor:
  - Vaccination status of the child as indicated by finger marking. In areas without proven resistance, the parent's word (history) can also be recorded, but should be treated separately during data analysis;
  - House marking: does the house mark correctly reflect the vaccination status of the children inside;
  - These 2 indicators give the proportion of children and households missed. Criteria should be established for designating an area as high risk area and defining the action to be taken.
- Additional indicators:
  - The reason for children not having been vaccinated;
  - Areas missed or poorly covered;
  - The information given by the team to the parents (next round, routine immunization, etc.) and the attitude;
  - The information source from which the parents heard about the campaign;
  - District, provincial and national monitors may add: the availability and quality of micro plans, maps, social mobilization materials and logistics (cold chain), etc.; the quality of the team's performance; evening meetings and other organizational aspects if considered relevant and problematic.

Technical sheets for polio eradication

X. SIA quality indicators

This document is part of a series of technical sheets to be used for the preparation and implementation of quality SIA, surveillance reviews or case investigations for polio. The series of sheets consists of the following:

I - Coordination	IV - Supervision	VII - Cold chain, VVM	X - Quality indicators
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III - Mapping	VI - Finger marking	IX - Monitoring	XII - AFP Surveillance review

Objective: Evaluation of SIA with the help of quality indicators is aimed at 1) the detection, follow up and correction of problems, and 2) giving a description of the quality of the campaign on basis of some standard criteria.

The choice of the indicators depends on the specific context of the country or area, but the basic indicators below are recommended everywhere. The purpose being primarily to detect weaknesses and address them, the indicator's choice must be based on identified or expected problems, rather than academic interest.

In order to be able to deal with weaknesses anywhere, process indicators are as important as outcome indicators.

After choosing the indicators, the data collection tools must be adapted to reflect the indicators. Equally important is it to set up a mechanism and templates for data collection, transfer and analysis before the start of the campaign at all levels.

There are 5 data collection tools that can be used for the required analyses:

- A form to collect data on the level of preparedness of health centre or Districts health office, to be filled out by the national/regional supervisors.
- The tally sheets.
- A tool for monitoring and rapid assessment for independent monitors (see the TS on monitoring).
- A form that allows evaluating the quality of work of vaccination teams and supervisors, to be filled out by the national/regional supervisors.
- Specific investigations, for example on refusals or communication, will require forms designed for that topic.

Basic indicators (per region/district)

- Number of children reached/missed by age group based on tally sheets and rapid assessment
- Percentage of houses reached/missed
- Percentage of houses marked correctly/incorrectly
- Percentage of teams with a detailed map and itinerary of their catchment area
- Percentage of teams with a vial with VVM in state 1-2 or 3-4
- Percentage of teams with at least one member recruited in the team's catchment area
- Percentage of teams with both members trained
- Percentage of parents aware of the campaign before the arrival of the vaccination teams

Additional indicators depending on national or regional constraints

- Percentage of Districts/HC with finalized micro plan and funds before the start of the campaign
- Percentage of teams with both members as per the micro plan
- Percentage of teams with at least one female member
- Percentage of teams respecting the rules of IPC (Inter Personal Communication)
- Percentage of teams having been visited at least once a day by a supervisor
- Percentage of supervisors with a map with the location of the teams
- Number of HC/Districts/Regions having a daily meeting with the supervisors
- Number of children vaccinated and households visited compared with the same day during the previous round.
- Percentage of households with children absent, but revisited during the campaign
- Examples for specific investigations could be the relevance of various sources of information (radio, TV, traditional leaders) or number and location (ethnic/religious/geographic clustering and trends) of cases of refusal.