POLIO GLOBAL ERADICATION INITIATIVE

Methodology for Special Investigation Tool to identify reasons for missed children

World Health Organization

A. Description of the tool

What is it and why do we need it?

Objective of the tool
The objective of the special investigation tool is to help the GPEI identify the underlying reasons that lead to chronically missing children with OPV in high risk areas for polio transmission.

The tool is composed of 3 distinct sections, which need not be administered sequentially, but doing so would enhance the investigators' depth of understanding.

PARTS A and B are designed to evaluate the planning of SIAs, staff capacity, accountability, and leadership at the district (PART A) and sub-district levels (PART B). These parts review micro plans and documents related to planning and preparatory activities (e.g. funding, meetings, trainings) conducted prior to the most recent polio SIA and 2) also include rapid interviews with selected field staff.

PART C is designed to assess community perceptions and attitudes towards the polio programme and the vaccine, as well as the wider routine immunization system. It focuses on the community which triggered the investigation, and includes 1) rapid interview with one local, traditional or religious leader of that community and 2) a cluster survey of 20 households in the community.

When is it used?

A special investigation can be initiated by national/state/provincial authorities in response to one or more of the following triggers that identify a potentially serious problem of children being missed with OPV:

1. WPV or cVDPV case/cluster
Within 3 days of confirmation of the index case as positive for WPV or cVDPV. This investigation should be conducted in conjunction with the "detailed epidemiological case investigation" of the case.

2. Zero-dose AFP case/cluster
Within 7 days of an AFP case investigation identifying any children as never having received any dose of OPV (excluding the birth dose).

3. Cluster of missed children as identified by independent monitoring/LQAS

Within 7 days of the identification by external monitors of a community with a predetermined percentage of missed children through post-SIA independent monitoring or LQAS. Depending on the level of risk associated with the area and/or the severity of the problem, the special investigation may be conducted not only once but also immediately after 1 to 3 of the subsequent rounds of SIAs in order to track change. Countries may have different thresholds to classify an area as 'poorly covered' or 'chronically missed'; these should be determined immediately when contextualizing these guidelines for local use.

4 .Cluster of refusals during SIAs as identified through supervision or monitoring (IM/other):
Within 7 days of the identification of a community with a predetermined percentage or number of missed children due to refusal during the most recent SIA. Depending on the level of risk associated with the area and/or the severity of the problem, the special investigation may be conducted not only once but also immediately after 1 to 3 of the subsequent rounds of SIAs in order to track change. Countries may have different thresholds to classify a 'cluster of refusal' the definition of a cluster should be determined immediately when contextualizing these guidelines for local use.

5. Other reasons
Any other reason as identified by the country such as "low campaign awareness levels" as identified through locally established thresholds gathered by independent monitoring.

B. Usage of the tool

How should it be conducted?

Once one of the above 5 triggers is reported, a decision is made at the national or state level to conduct a special investigation using the standardized tool that has been adapted to the country/local context. The MOH and its partners, primarily WHO and UNICEF, should be part of each investigation. Any one agency may take the lead in conducting one part of the exercise (e.g. UNICEF conducting Part C) and in consolidating the results and finalizing the report in consultation with the investigation team. The absence of any one partner should be justified and documented (in the cover of the tool). All members of the team taking part in the investigation should be trained on the tool beforehand.

PART A: District/LGA assessment

1. It is conducted by a joint MOH/WHO/UNICEF team appointed by the State/Province
2. Key informants are;
    1) The senior District Official (or equivalent) who is accountable for polio (e.g. the District Coordinator in Pakistan, or the LGA Chairman/deputy Chairman in Nigeria)
    2) The District/LGA Polio focal point (either MOH and Partner agency)
    3) The District/LGA Communication Supervisor (or equivalent, such as supervisor for the communication network)

3. Documents to review include the most recent:
    1) District/LGA micro-plans, including logistics and supply plan
    2) District/LGA social mobilization plan
    3) Minutes of the most recent Task Force meeting
    4) Any pre/post-campaign dashboards, SIA data

PART B: Sub-district assessment

1. This assessment is to be conducted by a joint MOH/WHO/UNICEF team appointed by the State/Province

2. Key informants include:
    1) The sub-district polio focal point (such as EPI Manager)
    2) The Team Supervisor for the most recent campaign from the target community to be surveyed
    3) The sub-district Communication Supervisor (or equivalent, such as Supervisor for the communication network)

3. Documents to review include, the most recent:
    1) Sub-district micro plans, including logistics and supply plan
    2) Sub-district social mobilization plan
    3) Minutes of the most recent Task Force meeting
    4) Any pre/post-campaign dashboards, SIA data
    5) Training plan, attendance records and materials

PART C: Community assessment

1. Conducted by: a joint MOH/WHO/UNICEF team appointed by the State/Province in the case of one of the triggers mentioned above or a stand-alone social barrier emerging in a community.

2. Key informants include:

   1) Local, traditional or religious leaders for the "community risk assessment"
   2) One caregiver (ideally the mother) from each of 20 randomly selected households for the "Community household survey"

3. Selection methodology

   1) Local leaders: Request a social mobilizer (or local health worker if no social mobilizers are present) to identify the top 3 influential leaders for the community. Select one at random for the interview.

   2) Community household survey:

- 20 households must be selected for the community survey, and the selection must include :

  a) all households with a child meeting the trigger criteria (WPV/cVDPV case, AFP zero dose, missed children, or refusal) AND/OR

  b) additional randomly selected households with children under 5 years of age until 20 households are reached

- In the case of a zero-dose AFP, WPV/cVDPV case, include the index house and randomly select 20 households with children under 5 yrs of age in the immediate area around the index case.

C. Analysis and Reporting

For each investigation conducted, one organization (MOH, WHO or UNICEF) will be made responsible for compiling and analysing the data, using the locally adapted reporting templates. A comprehensive report should be completed and available for sharing within a suggested 1 week of the end of the investigation.

The report shall be shared with all partners in country, and to UNICEF/WHO focal points at Regional and HQ. The status of implementation of the actions taken against the recommendations laid out in the report will be tracked according to each country's current monitoring arrangement as defined in the emergency action plans. Additional monitors should be deployed during the next SIA, and results compared to the previous round data. If there is no improvement, an additional special investigation should be supported.