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National Primary Health Care Development Agency

REVISED GUIDELINES FOR THE IMPLEMENTATION OF IMMUNIZATION PLUS DAY'S (IPDs)

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Draft

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1. Introduction

Nigeria continues to implement the four globally recommended strategies for Polio Eradication:

- Achieve and maintain the highest levels of routine immunization coverage with OPV
- Establish sensitive surveillance to detect all cases of Acute Flaccid Paralysis (AFP)
- Conduct supplemental immunization activities (SIAs) with OPV,
- Carry our focused campaigns (mop up campaigns) to eliminate the last foci of transmission.

In 2006 Nigeria adopted an integrated strategy for Supplemental Immunization activities known as the Immunization Plus Days (IPDs). The IPDs are a strategy used to deliver OPV together with other vaccines as well as other child survival health interventions such as ITNs, ORS, anti-helminthics etc. IPDs were introduced following an extensive consultative process and were aimed at increasing community confidence in the Polio Eradication effort while at the same time contributing to reducing the high child mortality and morbidity in Nigeria. The IPDs are expected to contribute towards the achievement of the MDG 4 on child survival.

1.1. Objectives of IPDs

The **overall objective** of the IPDs is to achieve interruption of transmission of wild poliovirus in Nigeria through the delivery of supplemental Oral Polio Vaccine (OPV) to all eligible children in the country. To ensure that interruption of wild poliovirus transmission occurs in a manner that has maximum benefits on other efforts to promote child health, IPDs are used to scale up delivery of other routine immunization antigens as well as other child survival interventions.

The **specific objectives** of IPDs are:

- To deliver 2 drops of potent OPV vaccine to **all children** under 5 years in the country (or participating States and LGAs) in each IPDs round. OPV is delivered to all children regardless of their previous vaccination status.
- To deliver routine immunization vaccines as described in the national EPI policy to all eligible children, 0-11 months, according to the vaccination status and the national EPI schedule.
- To ensure that all pregnant women receive the TETANUS TOXOID vaccine as per EPI Schedule.
- To provide other child survival interventions as available.

The OPV dose administered during IPDs are considered "supplemental" doses and should be considered ADDITIONAL to the four routine doses as recommended in Nigeria's national EPI policy. The other vaccine doses administered during the IPDs, should be administered taking into account, the number of doses of vaccine the child has already received and the age of the child. The doses of the other vaccines (other than OPV), are to be considered as routine doses, and should be recorded in the child's vaccination card as well as in the immunization register at the health facility. While the OPV dose can be delivered by non-health workers, all the other antigens should be delivered by trained health workers.

Other child survival interventions that can be delivered during IPDs depending on availability include Vitamin A, anti-helminthics (de-worming medicines), Insecticide Treated Bed-nets (ITNs), Oral Rehydration Salts, Soap........etc. IPDs are also used to promote other public health activities e.g. Guinea Worm surveillance activities, outbreak response activities e.g. CSM response activities...etc

2. IPDs delivery strategy

The **operational target** of the IPDs is to ensure that all children in the target age group, i.e. children less than 5 years of age (0-59 months), in the areas participating in the campaign are reached and vaccinated with potent OPV vaccine. To ensure that this objective is achieved, a combination of vaccination delivery strategies has been used.

Since inception of IPDs in 2006, IPDs vaccination has been delivered through House to House (H-H) teams as well as at Fixed posts. Monitoring data indicate that a significant number of children continue to be missed by H-H and Fixed posts. **Child absent** from the house at the time of visit by the vaccination teams is a major reason that children remain un-vaccinated during IPDs. Child absent accounted for 53% of children left unvaccinated during the January 2009 IPDs, 50% during the February 2009 IPDs and 58% of children unvaccinated during the March 2009 IPDs. During the March 2009 IPDs, 84% of the children missed in the North-Central zone were due to child absent, 46% of the children missed in the North-East zone were due to child absent, 50% of the children missed in the North West zone were due to child absent, 52% children missed in the South East zone were due to child absent, 72% of children in South South zone due to child absent while 71% of the children missed were due to child absent.

The majority of absent children are in streets, playgrounds, naming ceremonies, markets, transit points etc. particularly in densely populated areas. Therefore, there was need to modify the existing team composition in order to have special teams to vaccinate eligible children seen in streets, playgrounds, naming ceremonies, markets, transit points etc.

Following the piloting of special teams in endemic states and subsequent endorsement by the 17th Expert Review Committee (ERC), the inclusion of special teams has been adopted.

2.1. Modified IPDS Delivery model

IPDs teams will now have 3 components

1. House-to-House (H-H)
2. Fixed Post (FP)
3. Special Teams (ST)

2.2. Components of IPDs Delivery:

2.2.1. House- to- House teams.

Members of house to house teams should be resident in areas assigned to them and chosen with consent of community leaders. The composition should be as follows:

- 2 vaccinators (to deliver OPV only)
- 2 recorders
- 1 supervisor
- Community Leader

2.2.2. Fixed Post:

Fixed posts will only be in functional health facilities that provide **regular** routine immunization services every month. During IPDs, the health posts should be organized in the form of child health week strategy i.e. provision of all routine immunization antigens together with other child survival interventions e.g. antihelminthics, growth monitoring etc. In every ward, there should be not more than 2 fixed posts. The team composition should be:

- 1 Vaccinator (health worker of respective health facility)
- 1 recorder (health worker of respective health facility)

2.3.5. Recorder must be:

- Health worker or Teacher who can easily verify the age of the children and record properly
- Selected by the Ward Focal supervisor within the IPDs catchments area under guidance of the community leaders
- Endorsed by LGA Team

2.3.6. Community Leader/Crowd controller must be:

- Community Leader
- Selected by the community leaders within IPDs catchments area

2.3.7. House to House Vaccinator must be:

- Mature females
- Preferable members respected CBO's in the community
- Selected by the community

2.3.8. House to House Recorder must be:

- Mature females
- Preferable community leader or members respected CBO's in the community
- Selected by the community

2.3.9. Special Team Vaccinator

- Should be a member in the target community
- Gender to be determined by the situation in the locality
- Preferable community leader or members respected CBO's in the community
- Selected by the community

2.3.10. Special Team Recorder

- Mature females
- Preferable community leader or members respected CBO's in the community
- Selected by the community

2.3.11. Special Team Town Announcer/Community Mobilizer

- Should be a member in the target community
- Selected by the community

<u>Reminders for team selection</u>

- **Team selection is a major problem of the failure in immunization activities**
- **Avoid young females in the team**
- **IPDs Supervisors must be Health Workers.**
- **Vaccinators must be health workers who can give injection.**
- **Recorder must be a health worker or a teacher**
- **Crowd controller must be a respectable community leader**

Effective leadership and oversight of immunization activities at LGA level is critical to ensure that coverage and quality of immunization activities reaches the level required for interruption of wild poliovirus transmission to occur. The 17th meeting of the Expert Review Committee noted and appreciated "major increase in visibility of political commitment and oversight of polio eradication activities by National, State and Local Governments". The Experts however noted, that although the increased commitment had began to trickle down, there is still some way to go with regard to full engagement of Local Government Chairmen".

The following specific tasks have been proposed for LGA chairmen to undertake

- Establish inter-sectoral committees at the LGA level i.e. LGA State Task Force or LGA Inter-Agency Coordination Committees
- Direct that regular and timely meetings of the LGA inter-sectoral commitments to oversee coordination of Polio eradication and routine immunization activities and provide LGA Chairman with reports of these meetings
- Regularly meet with traditional and religious leaders to discuss how they could be effectively engaged in mobilizing their communities to participate in IPDs as well as routine immunization activities
- Identify and deploy senior members of administration to supervise pre-implementation and IPDs Implementation
- Ensure adequacy of and timely release of LGA counter-part funding for IPDs and Routine Immunization
- Establish mechanisms to hold vaccinators and supervisors accountable to achieving a target of > 90% coverage in each ward, as assessed by independent monitoring, with immediate re-vaccination of an area that fails to achieve this target
- Design and implement mechanisms at LGA level to acknowledge and reward excellent performance and sanction poor quality performance.

3.2. State and LGA Inter-sectoral coordination bodies

Inter-sectoral coordination is essential for the success of public health programmes, immunization, inclusive. At state level, several Ministries, Departments and Agencies have important roles in ensuring successful immunization programmes. These include Ministries of Health, Local Government and Chieftaincy Affairs, Information, Education, Religious Affairs, Women's Affairs; State Primary Health Care Development Agencies (where these have been formed); Local Government Service Commission, National Orientation Agencies....etc.

Coordination and collaboration between the Executive Arm of Government and the Legislature can ensure significant improvement in immunization programme delivery and coverage. In this regard, the roles of the State Houses of Assembly at State level and LGA councillors at LGA level should be strongly encouraged.

Civil society and community leaders are a major force in effective inter-sectoral coordination and should always be part of this effort. Representatives of traditional and religious leaders, professional organizations, volunteer and community based organizations should be invited to participate in inter-sectoral bodies at both State and LGA level.

The 15th meeting of the Expert Review Committee (ERC) on Polio Eradication and Routine Immunization (July 2008) recommended the establishment of high-level inter-sectoral committees in northern endemic states under the auspices of the Governor. These inter-sectoral committees, which could be in the form of a State Task Forces (STF) on Polio Eradication and Routine Immunization would be responsible to ensure that directives from the national level are translated into real improvements in IPDs coverage at State

"plus" (b) ensuring that laid down standards for storage, transportation, distribution and use of vaccines and other supplies are adhered to at all levels (c) ensure that vaccine stock levels are regularly monitored and any stock-outs investigated and reported (d) ensure that all cadres involved in immunization (vaccinators, supervisors, Ward Focal Points, Cold chain officers) receive regular and quality re-fresher training on logistics issues, particularly vaccine management (e) liase with the Social mobilization sub-committee to ensure timely distribution of adequate quantities of IEC materials and materials that will enhance programme visibility.

3. **Social Mobilization sub-committee:** This sub-committee is responsible for (a) reviewing state advocacy, communication and social mobilization work-plans and budgets (b) ensuring updated advocacy schedule and materials to traditional, religious and other leaders in the State (c) ensuring adequacy of appropriate IEC materials at all levels (c) ensuring effective collaboration with print and electronic media in the state to ensure timely and effective dissemination of programme messages (d) ensure that State and LGA officials responsible for social mobilization and communication e.g. Health Educators, Social Mobilization Officers etc undergo regular refresher training in advocacy and communication skills (e) ensure that all vaccinators, supervisors and ward focal persons are trained in Inter-personal communication (IPC) skills prior to each IPD round as well as in skills in conducting effective community dialogues (f) ensure that all priority health facilities delivering regular routine immunization services have effective and regular community link with the community leaders in their catchment communities

4. **Finance sub-committee:** This sub-committee is responsible for (a) preparing and updating state budgets for routine immunization and IPDs (b) ensuring timely and transparent financial information is provided to all members of the State Inter-sectoral committees(c) identify mechanisms for resource mobilization to fill gaps not met by funding from Federal, State, LGA and partner sources (d) update and disseminate recommended financial management guidelines to LGAs (e) prepare regular financial reports

3.2.1.3. Proposed Methods of Work

Secretariat: The State will provide a secretariat for the State inter-sectoral body and this secretariat will be under the overall technical guidance of the Honourable Commissioner of Health. The secretariat will be responsible for documentation, arrangements for meetings, preparation and dissemination of minutes and invitations to meetings. The secretariat will also be responsible for provision of secretarial services to the main committee as well as to the subcommittee.

Frequency of Meetings: The State inter-sectoral committee shall meet at least once a month, or whenever the Chairperson/co-chairperson convenes a meeting. The secretariat shall ensure that minutes are taken during each meeting and that minutes are disseminated to all members within one week of each meeting. A quorum of the State Inter-sectoral committee shall constitute at least 50% of the members.

Performance Indicators: The following are to be used as monitoring indicators to assess performance of State inter-sectoral committees:

- State 12 month (Jan-Dec 2009) plan for Polio Eradication and Routine Immunization discussed and endorsed by the State inter-sectoral committee;
- State Inter-sectoral committee has at least 1 meeting prior to each IPDs round in the state
- Quarter report on Status of Polio Eradication and Routine Immunization in the State, prepared by State Task Force and submitted to His Excellency Executive Governor. [This report should facilitate the submission by the office of the Executive Governor to the National Economic Council as per commitments made by all Executive Governors in February 2009]

secretariat. The secretariat will be responsible for documentation, arrangements for meetings, preparation and dissemination of minutes and invitations to meetings.

Frequency of Meetings: The LGA inter-sectoral committee shall meet at least once a month, or whenever the Chairperson/co-chairperson convenes a meeting. The secretariat shall ensure that minutes are taken during each meeting and that minutes are disseminated to all members within one week of each meeting. A quorum of the State Inter-sectoral committee shall constitute at least 50% of the members.

Performance Indicators: The following are to be used as monitoring indicators to assess performance of State inter-sectoral committees:

- LGA 12 month (Jan-Dec 2009) plan for Polio Eradication and Routine Immunization discussed and endorsed by the State inter-sectoral committee;
- LGA Inter-sectoral committee has at least 1 meeting prior to each IPDs round in the state
- Monthly progress reports on Routine Immunization and Polio Eradication prepared and submitted to the State

3.2.2.4. Proposed members of LGA Inter-sectoral Coordination bodies

- LGA Chairman, Chairman
- LGA Director Personnel Management
- Councillor for Health
- District Head
- State Technical Facilitator
- Women Development Officer
- LGA Information Officer
- LGA NOA Officer
- LGA PHC Coordinator, Member/Secretary

3.3. Systematic Engagement of Religious and Traditional Leaders

In recent years, the critical role of religious and traditional leaders in Polio Eradication and other immunization efforts has not been pursued in a systematic manner and this has contributed in no small measure to persistent gaps in programme performance.

Traditional and religious leaders (a) wield considerable social and political influence (b) have an established network of people and organizational and physical infrastructure down to community levels (c) are a source of credible information for their followers (d) provide motivation to act for the wider social good (e) can sanction certain behaviours or actions (f) can become allies in dispelling rumours and reducing resistance (g) are often willing to act on their own with minimum support[2].

The national level is promoting a more systematic engagement of Religious and traditional leaders and is in close dialogue with leaders of the Islamic and Christian Faiths in the country. It is expected that this dialogue will soon result in a joint programme of action.
At State level, Executive Governors are encouraged to ensure a systematic, deliberate and purposeful engagement and involvement of Religious and Traditional leaders. The State Inter-sectoral bodies are expected to support this effort through:

- Supporting the preparation of at least quarterly meetings between His Excellency the Governor and the religious and traditional leaders at State level

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[2] **UNICEF (2004).** Building Trust in Immunization. Partnering with Religious Leaders and Groups

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3.4. Milestones in IPDs Planning

4 weeks to implementation

- Hold state-level technical meeting to discuss previous round performance, risk status of LGAs, contributing factors to performance e.g. funding delays, procurement of pluses, logistics and personnel issues etc., and high risk operational plans to come up with the way forward including draft schedule of activities for upcoming round
- Finalize draft schedule of activities which should include meeting of the state technical team with the State Task Force/ICC
- Some of the issues that the State Technical Team should discuss with the State Task Force include:
    - Government oversight (coordination at state and LGA levels, counter-part support e.g. additional personnel and logistics, pluses etc.)
    - Programme awareness, sensitization and mobilization (flag-offs, airing jingles, documentaries on state TV and radio, covering events like rally and other media activities, banners and aprons for team members etc.)
    - High level supervision and monitoring in the field
- Hold State Task Force/ICC meeting
- State Task Force/ICC to form sub committees charged with responsibility for each component of the IPDs (Logistics, Social Mobilization, Technical and finance) and designate membership terms of reference for each sub committee.
- Task Force/ICC to announce date of upcoming IPDs-also on TV, radio and in newspapers, set date for meeting with LGA Chairmen, draw-up supervision plan for IPDs, and set date for meeting with Governor.
- Prepare meeting minutes for feed-forward to central level. The minutes should be circulated within 3 days after the meeting to ensure timely implementation of agreed action points
- STF/ICC sub committees (Logistics, Social Mobilization, Technical and finance) to draft individual work plans and submit same to the technical committee for vetting and forwarding to STF/ICC for endorsement.

3 weeks to implementation

- Training of State Technical Facilitators and LGA team
- STF and LGA team plan LGA Task Force meeting
- Hold LGA Task Force meeting (LGA chairman, senior traditional rulers and religious leaders e.g. district heads, political councilors, other technical partners etc.) to address issues as in State Task Force meeting above, including social mobilization and media activities planning.
- LGA Task Force to form sub committees for each component and designate membership of each sub-committee with ToRs.
- Set date for meeting with Ward Focal Persons, Ward Heads, prominent community (political, traditional and religious) leaders
- Prepare meeting minutes for feed-forward to State level. The minutes should be circulated within 3 days after the meeting to ensure timely implementation of agreed action points
- Commence planning activities with schedule at LGA level (see details of micro-planning below)
- Sub committees to develop and share work plans with LGA Task Force for endorsement. This now becomes the working document for the LGA after harmonization.
- LGA sub-committee on logistics to conduct inventory of all cold chain and implementation materials (megaphones, aprons, etc) and forward to LGA Task Force with recommendations on how to bridge any identified gaps.
- Commence social mobilization activities (Advocacy, Sensitization meetings, Media,etc)

2 weeks to implementation

In addition, LGAs and ward remain high risk because special populations are not adequately planned for and not reached. These special populations include nomads, migrant farmers and fishermen, riverine communities etc.

Members of the state and LGA technical teams should be oriented on risk analysis using the criteria below for standardization on how to classify LGAs and Wards in their respective states into very high risk, high risk, and low risk for polio transmission as follows:

- **Very High Risk LGAs:** Evidence of continued and / or intensified transmission - All LGAs with at least 10 WPVs in past 3 years should be classified as Very High Risk LGAs
- **High Risk LGAs:** All LGAs with a total score of 6 and above from the combination of variables below:
    - All LGAs with lower than 10 WPVs are to be given a score of 1 for each year WPV was reported. [Maximum score was 3].
    - Any LGA with a WPV in last 6 months to receive score of 2 [Maximum score 2]
    - Any LGA with AFP zero dose cases in the last 6 months (regardless of number of AFP cases with zero dose) had a score of 2 [Maximum score 2]
    - Any LGA with cVDPV (regardless of the number of cVDPVs) in the last 6 months had a score of 2 [Maximum score 2]
    - Any LGA with wards having at least one missed settlement using the settlement analysis OR missed children (monitoring data) >10% had a score of 1 for each round of the 3 most recent rounds conducted (maximum is a score of 3 i.e. more than 10% in last 3 rounds)
    - Any LGA with non-compliant households > 100 had a score of 1 for each round (maximum score is 3 i.e. more than 100 non-compliant households in all 3 rounds)

- **Low Risk:** All LGA with a score of 5 and below should be categorized as low risk.

Qualitative reports from supervisory checklist analyses, daily LGA and Ward evening meeting minutes should also be taken into account when finalizing the risk status of LGAs. Where-ever quality the qualitative reports indicate that significant numbers of children were missed during previous campaigns, the LGA should be categorized as high risk.

4.1. 2: Prioritization of problems in high risk areas

In the very high risk and high risk areas, prioritize the main reasons for missed children. These can be a combination of:

- Settlement not visited
- Houses not visited
- Non-compliance
- Child absent

- **Settlements/Houses not reached:** Conduct a field visit to the area where settlements/houses are not being reached in previous rounds and pin-point the reason teams are not reaching these areas.
    - If the area is easy to reach, then the problem is team performance.
        - Firstly, check if the daily workload is realistic for the number of teams. If the workload is fine, then it is a problem of team performance. Therefore, re-look at issues of team selection, training and plan for strengthened supervision.

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- Nursery schools, Quranic Schools, crèches and other schools that may have < 5 year olds: Although planning for these schools should be part of the operational plans, the plan for these schools needs to be developed separately as a sub-plan within the plan for implementation:
  - ALL schools with children < 5yrs old must be line listed. Note: Such schools include quranic schools, established Islamyyia schools, nursery schools, crèches...etc
  - Where possible number of eligible children in each school should be obtained.
  - In the case of quranic and Islamyyia schools, the names and status as well as religious sect affiliation of the Mallam should be compiled with the list.
  - Develop separate operational plans for the Quranic schools. (Note these schools are covered usually on Saturdays and Sundays).
  - Involve the Quranic school teachers in the operational plans.
  - At the planning phase, Quranic teachers must be involved in the planning and outlining how the schools will be covered.
  - During implementation ALL QURANIC schools should be visited and those not visited or where children not vaccinated MUST be followed up after the exercise to ensure all children are vaccinated.

4.2. Steps in Micro-planning

Micro-planning is mainly done at the ward and settlement level. The responsible persons are the Ward Focal Person and IPDs Team Supervisor. In order to have a detailed settlement based micro-plan, the following steps should be followed:

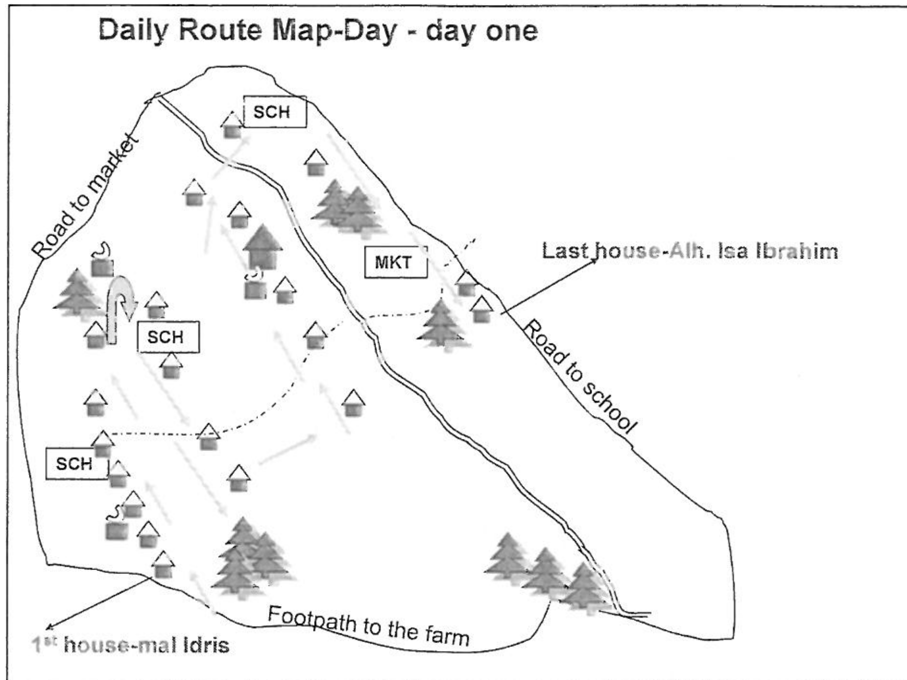
Step 1: Ward level micro-planning meeting:

It is recommended that the Ward Councillor chairs the ward level micro-planning meeting. The Ward Focal Person should be the secretariat of the meeting and should ensure that the Village Heads, Ward Heads, Traditional Leaders and prominent Religious Leaders, Ward Councilors have:

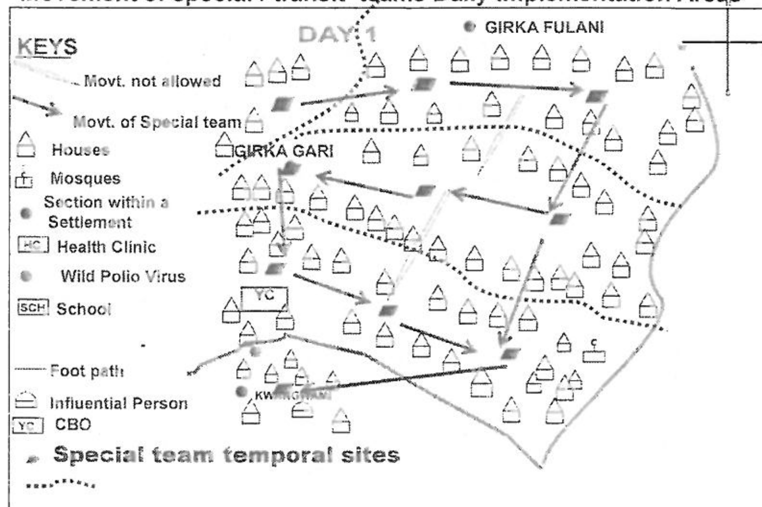
- a list of all settlements with estimated populations and other demographic information
- boundary information in their area of jurisdiction
- markets, motor-parks, churches, schools including Quranic schools
- Names of possible IPDs team supervisors (responsible persons with SIA or community health experience in the area to minimize selection bias).

At the meeting:

- the ward focal person compares information of settlements, population, other demographics, boundaries, markets, motor-parks, churches, schools etc from prior rounds with new information brought in by the Ward Head, Councilors etc.
- based on submitted population, the Ward Focal Person estimates the number of House-to-house Team by dividing the total target ward population by 1,000 (250 children per day for 4 days). This will determine the number of IPDs teams for the ward.
- In consultation with community leaders for terrain and spread of settlements, divide the ward into the number of House-to-house teams calculated above into well defined catchment areas for IPDs teams
- The borders should be physical / geographical structures that can be easily used as reference points (e.g. roads, rivers, social and natural boundaries / structures) for the IPDs team catchment area
- It is expected that 2 fixed posts will be established by ward and these will be located at health facilities that deliver regular routine immunization services.
- The identification of needs for special/transit teams will be determined by the population density and transit points in the ward.



- For Special Teams that operate **mostly in densely populated settlements and settlements where previous IPDs data analysis revealed that most children were missed because of child absent.**
  - The supervisor should clearly indicate the specific areas to be covered by the Special Teams in the daily route map. These areas should be cleared documented by listing all settlements with their streets, playgrounds, motor parks, schools, markets, water-points etc.
  - The Supervisor will identify the Special Teams start point, end point and route map for each day. They should be working in the same segment of the settlement as the house to house teams



- In addition, Special Teams should be assigned to transit areas such as motor-parks, markets and churches, and should be in these points the whole day. If these are regular

State Technical facilitators are expected to be senior health workers with experience in previous IPDs. They should be senior staff of SMOH or tutors from schools of health technology, nursing schools...etc.

The Terms of Reference (TOR) of the State Technical Facilitators include:

- To support LGA team implement high quality micro-planning activities in all wards, including undertaking risk analysis, ensuring community participation in micro-planning at ward level, development of standard ward micro-plans, development of daily implementation plans as well as ward level maps and daily itinerary maps;
- To support LGA develop social mobilization plans and implement planned advocacy and mobilization activities including systematic engagement of traditional and religious leaders and effective community dialogues
- To support LGA team to ensure selection of all cadres of personnel involved in IPDs in accordance with laid down selection criteria
- To support LGA team plan and implement high quality training activities
- To support LGA team to prepare and implement logistics plan
- To support data analysis, review and use for action
- To support supervision and monitoring of pre-implementation activities
- To support supervision of IPDs implementation including participation in daily review meetings.

5.2.2. Ward Focal Person (WFP)

Ward Focal Persons are expected to be senior health workers with minimu qualifications of CHO, Nurses or midwife. WFPs could also be selected from tutors of nursing schools, schools of health technology....etc It is preferable that the Ward Focal Person is based in the ward in which he/she will be deployed during the IPDs.

The Terms of Reference (TOR) of the WFP include:

- To oversee and ensure high quality micro-planning activities in their wards of assignment, including undertaking risk analysis, ensuring community participation in micro-planning at ward level, development of standard ward micro-plans, development of daily implementation plans as well as ward level maps and daily itinerary maps;
- To develop ward-level social mobilization plans and implement planned advocacy and mobilization activities including effective community dialogues
- To ensure selection of all members of vaccination team and supervisors in accordance with laid down selection criteria
- To plan and implement high quality training activities
- To ensure effective ward level logistics plan
- To support data analysis, review and use for action
- To support supervision and monitoring of pre-implementation activities
- To support supervision of IPDs implementation including participation in daily review meetings.

5.2.3. IPD Team Supervisors

IPDs Team supervisors should be health workers with minimu qualifications of CHO, Nurses or midwife. IPDs supervisors could also be selected from tutors of nursing schools, schools of health technology....etc It is preferable that the IPDs supervisors are based in the ward in which he/she will be deployed during the IPDs.

The Terms of Reference (TOR) of the IPDs supervisors include:

5.3.2. LGA level Training

The **trainees** during the LGA level training are the LGA DPHC, LGA Immunization Officer, LGA Cold chain Officer, Ward Focal Points and Team supervisors. The **facilitators** of the LGA level training are the State Technical Facilitators and members of the State team i.e. Director PHC, State Immunization Officer, Cold Chain Officer, State Health Educator, State Disease Surveillance and Notification Officer, State Epidemiologist, NPHCDA staff and partner agency staff.

The duration of the LGA level training is expected to be 2 days, during which the following topics should be covered:

- Current status of Polio Eradication in Nigeria and in the different geo-political zones and states
- Review of recent IPDs performance
- An overview of IPD/SIA process (micro-planning, team composition, antigen administration, house and finger markings, revisits, AFP/guineworm surveillance.
- TOR
- Social Mobilization (advocacy, visibility, awareness and acceptance
- IPC skills.
- Logistic and cold chain maintenance.
- Practical on the use of all data management tools.

5.3.3. Ward Level training

The **trainees** during the ward level training are all vaccination team members.. The **facilitators** of the LGA level training are the LGA technical team (State Technical Facilitators, LGA DPHC, LGA Immunization Officer, LGA Cold chain Officer) Ward Focal Points and Team supervisors supported by members of the State Technical Team (i.e. Director PHC, State Immunization Officer, Cold Chain Officer, State Health Educator, State Disease Surveillance and Notification Officer, State Epidemiologist, NPHCDA staff and partner agency staff).

The duration of the ward level training is expected to be 1 days, during which the following topics should be covered:

- Current status of Polio Eradication in Nigeria and in states and the LGAs
- Review of recent IPDs performance
- An overview of IPD/SIA process (micro-planning, team composition, antigen administration, house and finger markings, revisits, AFP/guineworm surveillance.
- TOR
- Social Mobilization (advocacy, visibility, awareness and acceptance.
- IPC skills.
- Logistic and cold chain maintenance.
- Practical on the use Tally sheets, EPI documents.

The following should be emphasized during the training of vaccination teams:

- Reasons for modifying IPDs model.
    - Reasons for missed children in particular Child Absent.
    - Results of piloted street immunizations
- Operationalization of teams activities
    - Areas to be covered by the House to House and Special Teams
    - Emphasis on daily workplan for each component
    - Visibility, acceptability, timing of work, and systematic movement of the teams

5.3.6. Town Announcers training

This training for town announcers to be conducted at ward level 1 day prior to the start of the campaign is expected to cover the following topics:

- IPDs key Messages
- Use of Megaphone
- Duration of announcement
- IPC skills
- Days of implementation

Identified members from the consensus list should be informed about the venue and time of training. Invite the religious leaders to address the Ward Focal Person and IPDs teams on issue of ethics and attitudes. The training should be at the ward level for a single day.

5.4. Supervision

The importance of selection of appropriate personnel and training to the overall success of the IPDs cannot be over-emphasized. It is therefore strongly recommended that these activities are very closely supervised by members of LGA and State teams. A feedback of these important activities should be made to the State and LGA inter-sectoral committees, and wherever necessary, intervention from these committees may be required to ensure that the laid down recommendations are strictly adhered to.

6. Social Mobilization

6.1. Advocacy

State technical team advocates to State Task Force on key social mobilization issues that need to be conducted (4 weeks before implementation). Some key issues to be discussed with State Task Forces include:

- Discuss the social mobilization action plan
- States and LGAs have functional social mobilization committees to address communities on PEI activities including delivery strategies to be used e.g. House to House, Special Teams and Fixed Posts.
- State and LGA level flag off s
- Rallies in high risk LGA (state level flag off) and Wards (LGA level flag off)
- Intensive radio announcements 2 weeks prior to and during the IPD – at least 8 announcements per day
- Intensive TV announcements 2 weeks prior to and during the IPD – at least 8 announcements per day
- Involvement of the media in monitoring and reporting on IPDs –
- Display of street banners in urban settings and at LGA HQ level – at least 10 banners per city; at least 4 per LGA HQ
- Display of banners at fixed / mobile posts – every FP/MP
- Assessment of Mosques to plan mosque announcements – hold a meeting with Islamic leaders to plan for and discuss what announcements can be held in mosques (when/how many/how monitored)
- Involvement of community based organizations e.g. FOMWAN (in the north) to decide on a strategy to reach the mothers
- Advocate with state and LGA level Rotary volunteers as volunteers prior to and during the IPDs

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⇒ *Asking the parent/caregiverr to inform others and thank them after administering the vaccine*

6.2.2. Consideration for special teams:

Because of different operational requirements, mobilization to enhance community acceptance and in order to reach more children outside houses, there is need for special consideration, as follows:

Visibility of Special teams

- Special Teams must be positioned in a place which is accessible to all the people in the area or rather from where they can target all people passing by. They should be positioned outside houses in busy street junctions. Streets that are long should be sectioned into two or more sectors depending on the length of the Street.
- In markets and transit points, the teams should be stationary at the market gates and additional team (if available) to walk around within the market .
- Banners should be displayed by special teams working in markets, motor parks etc.
- Special teams should be equipped with attention attracting instruments such as loud speakers, whistles, bells, tambourines, Gambara (where megaphones are not available).

6.2.3. Increase acceptability

- Few days before implementation, a community dialogue/**sensitization** with local leaders showing pictures of polio victims and prominent people vaccinating children should be conducted in the settlements to be visited by special teams
- Ensure that the special teams have gender balance in areas where mothers with children on their backs may not be easily approached by a male
- The special team members should hang a laminated poster on their necks with a picture of polio victims on one side and a picture of prominent traditional / political leaders vaccinating children .
- Ensure the special teams have number of incentives more than the doses of OPV allocated to the team. On arrival at the posts, as a catalyst for mobilizing more children free incentives (sweets) should be distributed to children even if over age to encourage them to bring their younger siblings; before starting vaccination. However these over age children MUST NOT be vaccinated but can assist in mobilizing eligible children. (Eligible children should not be able to reach across their ear or should not have shed any milk teeth.)
- Develop monitoring and security plan for the commodities.
- Collaboration with market and motorpark management committees
- There should be active involvement of political leaders e.g. Ward Councilors in their wards.

7. Logistics and vaccine supply

Since the micro-plans are being updated, it is important that there should be adequate logistics e.g. vaccine carriers, ice-packs, aprons etc. and levels of available vaccines. Therefore an inventory of cold chain capabilities at LGA and ward levels to ensure provisions of adequate vaccines and logistics for all teams (i.e. carriers, ice packs, etc.) should be conducted. In addition, vaccine distribution plan based on revised/updated micro-plans should be developed.

7.2.3. Pre- implementation

(at least 1 week before the campaign), the LGA should

- Special teams for the streets and schools should take off in the identified first location in a street for the day (see diagram above). The town announcers continue their announcement around the location and when the number of children has reduced to minimum, the teams move to next location either on the same street or another street as in the plan. The process is repeated again and again until all planned locations have been covered effectively for the day.
- The itinerary of teams should cover the most densely populated areas in the first two days leaving the less populated areas for the remaining days.
- Implementation should be planned to commence in identified high risk or potential high risk settlement(s) in each ward.
- Implementation in these settlement(s) should be supervised by senior supervisors from Ward/LGA/State /National.
- Where high risk settlements are more than one day's activities, then the senior supervisors should cluster themselves and stagger the days of implementation to ensure proper supervision.
- Particular attention by Senior Supervisors should be paid to:
    - Densely populated areas
    - Nursery and Quranic schools
    - Hard to reach areas
    - Scattered communities
    - State and LGA borders

To make Special Teams more effective, their activities should take into account the time when the children will be outside in order to provide the best opportunity for vaccinating children that are usually missed by House to House teams due to child absent. Therefore,

- The Special Teams in streets should work until children have closed school to catch many children on their way back home
- For teams covering schools, they should be there when most children have arrived.
- In major transit points (e.g. markets, motor parks, churches etc.), the Special Team's timings should be planned as per the load and timing of the transport, church sessions etc. For example, at a bus stop, teams should be planned accordingly to cover all children coming and going through those transit points.
- Preferably a Special Team should work not more than 6 hours.

8.3. Revisits

- State teams should provide broad guidelines for revisit
- Emphasis should be placed on revisits during training activities
- All supervisors should ensure that teams are properly recording houses where children are absent for revisits
- Each ward/team should have clear revisits plans.
- Teams should keep accurate records of households for revisits
- Supervisors should check that this is being done
- Review meeting should be used to track documentation as well as revisits of children missed previously.
- Fully involve the Community Leader in the team to ensure revisits are done.

Note: Tracking of children missed should be continued until ALL children are vaccinated even after the round!

- Should discuss **process indicators** (team composition, time of take off, use of micro-plans, availability of logistics etc) based on the findings of the supervisory checklist from the monitors and supervisors.
- Should review the daily **outcome (performance) indicators** of teams such as coverage. The following should be discussed:
  - Number of children vaccinated
  - Number of doses administered
  - Number of non compliance households and missed children
  - Number of children for revisits.
  - Outcome of the day's in-process monitoring
  - Availability of supplies
  - Number of AEFIs observed
- Should develop plans to deal with all issues identified at the meeting the next day.

Process and impact indicators are important to identify where there are problems to be rectified immediately.

The important data tool for quickly monitoring performance (e.g. missed children, missed settlement) is the tally-sheet supported by data from independent monitors. Therefore, the tally-sheet must capture all information (name of settlement, number vaccinated, zero dose, non-compliance etc.) by settlement. The tally-sheet has been revised to capture these information by settlement to be used for accountability of team performance (see annex).

- At the end of each day, using the revised tally-sheet from each IPDs team supervisor, the Ward Focal Person should countercheck the list of settlements visited by the team with the original list of settlements as per community leader signed and verified microplan.
- The number of children reported vaccinated in each settlement should-be counterchecked with the populations originally submitted by local leaders.
- If either a settlement is missed or if the number of children reported vaccinated by a specific team in the settlement is less than 90% of the target population, the settlement should be redone
- From Day 2 – 4, the WFP should compare the performance reported by the teams in a settlement with the findings by the independent monitor, senior supervisors from Ward, LGA and State level in that particular settlement. Any report of poor performance or reported missed settlement must be redone
- The Ward Focal Person and LGA team should provide feedback to political and community leaders responsible for all areas that had poor team performance. Since they are the ones that provided the list of supervisors and team members, they should be held responsible and be reported to the LGA and State Task Forces for immediate appropriate action, and for subsequent planning process.
- The LGA team should keep trends of children vaccinated in each settlement in each ward and with end-process information from independent monitors, settlements that were missed should be mopped up immediately before payment of vaccination teams.
- The revised tally-sheet and monitoring data provides evidence of poor team performance that should be discussed at a feedback meeting at the Ward and LGA levels with disciplinary action taken against the specific team.

9. Independent supervision and Monitoring for IPDs

9.2. Independent Supervision for IPDs

Objectives:

- Supervision:
  - To verify teams are vaccinating all targeted children
  - **To verify information recorded by the teams in VHR areas**

- Guidance on use and completion (case scenario) of data tools

Training Materials:

- Visual aides: pictures of polio / measles victims, Traditional and Religious leaders vaccinating children.
- Each trainee should have copy of presentations
- Adequate data tools for the exercise

Number of data tools required to be provided at training for IPDS:
Each supervisor should get:

- 1 Implementation supervision checklist & summary form
- 1 OPV House to House Tally Sheet.
- 1 Inside Household monitoring form

i. **Selection of areas to be supervised: Very High Risk (VHR) and High Risk (HR) areas**
ii. **Independent supervision process:**

Independent supervisors are to:

- Be assigned particular H-H teams to follow for the entire 4 days of implementation by the LGA team.
- Be equipped with team daily implementation plan, catchment area map and data tools (tally sheets, supervisory checklist, summary sheet and inside household monitoring form).
  - 2 Implementation supervision checklist per day for 4 days = 8 supervisory checklist forms
  - 2 tally-sheets per day for 4 days = 8 tally sheets
  - For Catchments spot-checks:
    - Inside Monitoring: 2 forms per day for 4 days = 8 forms
- Take off early in the morning with the teams assigned.
- Accompany 1 subgroup (of one vaccinator and one recorder) of assigned H-H team, while the team supervisor accompanies the second sub group. This arrangement should be alternated daily.
- Record on their tally sheets the number of children seen vaccinated in the households by their sub group of the H-H teams as well as non compliance and revisits.
- Endorse the tally sheet of the subgroup accompanied by them on a daily basis.
- Submit copies of their tally as well as supervisory checklist to the LGA team at the daily evening review meeting.
  - NB: Independent Supervisors are to be observant and politely correct any gaps in team performance observed in the field. Independent Supervisors are also to keep personal copies of data submitted to the LGA team.

9.2.7. The roles of the supervisor are to:

⇒ Ensure vaccination teams adhere to the daily work-plan. A copy of the work plan shall be provided to the Supervisor by the LGA STF or Ward Focal Persons for their respective assigned areas.
⇒ Ensure all children are receiving OPV
⇒ Document all non-compliance and households
⇒ Document all Revisits
⇒ Ensure that the vaccination team conducts good IPC by properly introducing themselves and the purpose of their visit to the caregiver as well as asking the following:

- *How many children under five years of age do you have in your household?*
- *How many of these children have never received OPV before?*

- Support in planning supervisors' / monitors' itinerary
- Follow up on critical issues during meeting, use of GSM etc.
- Collect, cross check and collate data submitted on daily basis
- Evaluate their performance by day 2
- Provide feedback to monitors

9.3.3. Steps for monitoring process

Must be conducted by Senior Supervisors from LGA/State/National Levels and Independent Monitors as outlined in the steps below:

9.3.4. In Process (Duration = 3 days)

Should start on the second day of implementation

- Inside House
  - ⇒ Randomly Sample 5 households in a high risk settlement.
  - ⇒ Sample 2 high risk settlements/day (10 households /day).

- Outside House
  - ⇒ In the same high risk settlement for inside house process conduct outside monitoring.
  - ⇒ Randomly select 4 sites such as schools, street, motor parks, markets, etc.
  - ⇒ In each site Sample 20 children.
  - ⇒ In 4 sites = 20 children x 4 sites = 80 children per high risk settlement.
  - ⇒ Sample 2 high risk settlements per day (80 children x 2 high risk settlements = 160 children per day).

NOTE: During In Process:

- ⇒ Settlements should be monitored after the teams have visited such settlements.
- ⇒ Monitors should conduct outside monitoring with emphasis on churches (on Sunday), schools, transit points etc.
- ⇒ Data from in-process should be used to guide subsequent day's plans and therefore findings must be reported and discussed during the daily review meeting.

9.3.5. End Process (Duration = 2 days)

End-process should be done after the exercise is completed for 2 days. Within the LGA, independent monitors should be swapped to avoid conducting end-process monitoring in the same wards they conducted in-process.

- **Inside House**
  - ⇒ Randomly Sample 15 households in a high risk settlement.
  - ⇒ Sample 2 high risk settlements per day (30 households per day).
  - ⇒ In 2 days = 2 high risk settlements x 30 households = 60 households

- **Outside House**
  - ⇒ In the same high risk settlement for inside house monitoring conduct outside monitoring.
  - ⇒ Randomly select 4 sites such as schools, street, motor parks, markets, etc.
  - ⇒ In each site Sample 20 children.
  - ⇒ In 4 sites = 20 children x 4 sites =80 children per high risk settlement.
  - ⇒ Sample 2 high risk settlements per day (80 children x 2 high risk settlements = 160 children per day).
  - ⇒ In 2 days = 160 children per day x 2 days = 320 children total.

successes achieved are scaled up and sustained, while at the same time ensuring that challenges/gaps are effectively addressed.

10. Delivering Additional Child Survival Interventions during IPDs

During IPDs, it is expected that the fixed sites will deliver all antigens to children aged 0-11 months together with OPV. In addition to OPV and other antigens, several additional child survival interventions may be delivered including:

(a) Vitamin A
(b) Anti-helminthics
(c) Long Lasting Insecticide Nets (LLINs)
(d) Oral Rehydration Therapy.....etc

The IPDs have also been used to scale up surveillance activities e.g. as part of the Guinea Worm Eradication Effort.

To ensure successful Integration efforts, the following considerations must be given full attention:

(a) Coordination and collaboration between the different programmes involved e.g. Immunization programme and the Nutrition unit in the case of Vitamin A; Immunization programme and Malaria programme in the case of LLINs. This coordination should extend to all levels and should be characterized by regular joint planning and coordination meetings.

(b) Logistics plans: There should be timely and adequate supply of all the required logistics to ensure that all the expected target population receive the intended interventions in the required manner e.g. scissors for Vitamin A; adequate cold chain for vaccines...etc.

(c) provision of clear implementation guide-lines

(d) Effective communication plan:

11. Linkages between IPDs and Routine Immunization Strengthening

The enormous efforts put in place during the preparations and actual implementation of IPDs offer valuable opportunities to strengthen delivery of routine immunization activities:

(a) **Coordination and oversight** functions undertaken by the State and LGA inter-sectoral committees should include routine immunization strengthening. These committees should regularly review the status of routine immunization at State and LGA level, with particular emphasis on the status of implementation of the Reaching Every Ward (REW) approach. These committees should prepare regular reports to His Excellency Governor on successes/achievements, challenges and how the challenges can be addressed effectively and efficiently:

(b) **Advocacy:** The intensified advocacy efforts conducted as part of IPDs aimed at promoting ownership, commitment and participation of key leaders including political, religious and traditional leaders, should always include messages aimed at strengthening routine immunization as a way to sustain short term gains made during the campaigns.

(c) **Use of up-dated IPDs micro-plans:** The ward level micro-planning process recommended for the IPDs, that is done with involvement of health workers from health facilities in the ward, elected ward

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Table 1: Team Composition and Designation

Team Code: __________

SN	Name	Resident settlement	Designation
1			
2			
3			
4			
5			
6			
7			
8			
9			

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Table 3: List of Schools, Churches, Mosque, Markets and other places to be visited

SN	Settlement	Schools	Churches/Mosques	Markets	Other places
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
Total					

Table 5: Daily Vaccine and Logistics Requirements

Day	Doses of required				Quantity required			
	OPV	DPT	Measles	Yellow Fever	AD Syringes	5 ml Syringes	Safety Box	Cotton Wool
Day 1								
Day 2								
Day 3								
Day 4								
Mop up								
Total requirements for the catchment area								

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Catchment Area Map

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Annex 2: LGA social Mobilization Summary Form

LGA SOCIAL MOBILIZATION SUMMARY FORM

STATE....................................... LGA....................................... DATE............................... *IPD SM-3*

S/N	Ward	Number of community dialogues held	Traditional Leaders involved in mobilization? (Yes/No)	Religious Leaders involved in mobilization? (Yes/No)	Megaphone annoucements made? (Yes/No)	Mosque announcements made? (Yes/No)	IEC materials distributed? (Yes/No)	House-to-house mobilization taking place? (Yes/No)	Community-based groups/ organizations involved in mobilization? (Yes/No)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
	TOTAL								

Name/Signature of LGA Health Educator .... Date.................................

Submit completed form to State Health Educator at end of implementation

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Annex 4 OPV Tally Sheet for House-to-House Teams

OPV TALLY SHEET FOR HOUSE-TO-HOUSE

Use a separate tally sheet each day IPD T-1HH Rev. Apr 09

State: ____________ LGA: ______________ Ward: ______________ Date Date: ___________

Vaccination Team Code: __________ Recorder Name: ________________________________

		Name of Setlement		Name of Setlement		Name of Setlement		Sub Total
HOUSEHOLDS	*ZERO DOSE	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	OTHER DOSES	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
SCHOOLS	OTHERS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	QUR'ANIC	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
OTHER PLACES	*ZERO DOSE	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	OTHER DOSES	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL								
NC HOUSEHOLDS		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL								

Have you seen any case of Guinea Worm Disease in this settlement/village during the last 12 months?	Yes	00000 00000
	No	
	Total GWD	

Vaccination Team Supervisor's Name: ______________________ Signature: ______________

* OPV ZERO DOSE REFERS TO CHILDREN RECEIVING OPV FOR THE FIRST TIME

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Annex 6: OPV Tally Sheet for Fixed Post

OPV TALLY SHEET FOR FIXED POSTS

Use a separate tally sheet each day

IPD T-1FP rev Apr 09

State: ____________ **LGA:** ______________________ **Ward:** ________________

Health Facility name: ________________________ **Settlement:** ______________

Vaccination Team Code: ________ **Recorder's name:** __________________ **Date:** __________

						Sub-Total
OPV ZERO DOSE (receiving OPV 1st time)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
					Sub Total	
OTHER OPV DOSES (received OPV before)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
					Sub Total	
					Grand Total	

Have you seen any case of Guinea Worm Disease in this settlement/village during the last 12 months?	Yes	0 0 0 0 0 0 0 0 0 0	
	No		
	Total GWD		

Vaccination Post Supervisor Name: ______________________ **Signature:** __________

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Annex 8: Tally Sheet for PLUSES

TALLY SHEET FOR PLUSES BY TEAMS

Please use a separate tally sheet each day

Form IPD T-PLUSES rev Apr 09

State: ____________ LGA: ______________________ Ward: _______________

Vaccination Team Code: _________ Name of recorder: ___________________ Date: ___________

		Name of settlement		Name of settlement		Name of settlement		Sub-Total
Plus 1		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	Name ________	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
Total								
Plus 2		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	Name ________	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
Total								
Plus 3		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
		00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
	Name ________	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
Total								

Vaccination Team Supervisor's Name: ______________________ Signature: ____________

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Annex 10: IPDs Household Monitoring Form

IPDS HOUSEHOLD MONITORING FORM, NIGERIA

☐ In Process ☐ End Process IFD M-1

NOTE: Fill out one form for each settlement monitored. Select at least two settlements in the ward and visit five (5) randomly selected households in each settlement.

Settlement:__________ Ward:__________ LGA:__________ State:__________

Vaccination Team Supervisors Name __________ Vaccination Team Code __________

Serial number of House-hold	Was the Household Visited by Vaccination Team? (Y/N)	No. of Children Physically Seen in the Household		No. of Children marked with pen marker		Of the Children Marked			No. of children immunized for the first time (Zero Dose)		No. of Children Unvaccinated this Round	Reasons for Unvaccinated Children (Indicate Number of Children)					Was house marking correct (Y/N)	Did the family receive any Incentive (Plus)?	If yes identify the Incentive (Plus)	If no indicate the reason	Source of Information (Insert codes as key below)	Who influences Your Decision to Vaccinate your Children? (Insert codes as key below)
		0-23 Months	24-59 Months	0-23 Months	24-59 Months	No. of Children Vaccinated at Fixed Posts	No. of Children Vaccinated in House-to-House	No. of Children Vaccinated by Special Teams	0-23 Months	24-59 Months		Household not Visited	Child Absent	Non-compliance	Reasons for Child Absent (See Codes)	Reasons for Non compliance (See Codes)			Insert Codes as below	Insert Codes as below		
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)	(P)	(Q)	(R)	(S)	(T)	(U)	(V)	(W)
Total																						

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Any comments (e.g. did you find pockets of unimmunized children or houses not visited? Describe): __________

__________ (continue remarks at back of the form)

MONITOR'S NAME:__________ AGENCY/ORGANIZATION__________ SIGNATURE:__________ DATE:__________

CODES:

Reasons for Child Absent: 1= Playground; 2 = Market; 3 = School; 4 = Farm; 5 = Social event with mother; 6 = Others__________

Reasons for Non-compliance: 1 = OPV safety; 2 = Child sick; 3 = Religious belief; 4 = No felt need; 5 = Political differences; 6 = No caregiver consent; 7 = Unhappy with immunization personnel; 8 = Too many rounds; 9 = Reason not given

Types of incentive/plus (ALL THAT APPLY): 1 = Soap; 2 = Detergent; 3 = Biscuit; 4 = Sweets; 5 = Satchet milk; 6 = LLINs/ITNs; 7 = Others

Reasons for not getting incentive: 1 = Incentive not provided; 2 = Incentives exhausted; 3 = Not aware of incentives; 4 = Others (specify)__________

Source of Information (all that apply): 1 = Town crier; 2 = Media (radio or TV); = Traditional/Religious institution; 4 Neighbour, friend; 5 = Other sources; 6 = Not aware of campaign

Who Influences Decision To Vaccinate (all that apply): 1 = Personal decision; 2 = Husband; 3 = Traditional Leader; 4 = Religious Leader; 5 = Radio or TV; 6 = Neighbour, friend; 7 = Health worker; 8 = Others__________

NOTE: give original after daily activity to LGA STF or National External Consultant. Keep a copy for yourself.