

THE UNITED REPUBLIC OF TANZANIA



IMMUNIZATION AND VACCINE DEVELOPMENT PROGRAM (IVD)



MEASLES RUBELLA VACCINE INTRODUCTION  
GUIDELINE

2014



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## FOREWORD

Tanzania has been doing well in reducing child mortality in line with the millennium development goal number four (MDG 4). This has been possible due to various efforts by a number of stakeholders working tirelessly to prevent deaths of such vulnerable populations. Of its own importance was the commitment by the government through the National Development vision 2025, the national social development vision and the Poverty reduction strategy paper. These all emphasize health as an important ingredient to economic and national development of the country. In line with the millennium development goals, these visions and commitments by the government helped to focus on prevention of children deaths, in particular the vaccine preventable ones. As a result, much has been done to improve immunization through its Immunization and Vaccine Development Program (IVD).

Immunization and Vaccine Development Program operates under the directorate of Preventive Health Services in the Ministry of Health and Social Welfare (MOHSW). Expansion of activities by IVD has resulted into coverage of above 85% of most of health facilities in the country. Coverage of immunization is projected to reach 95% of all available health facilities in 2015. Such rapid growth of immunization services in Tanzania worth commending. More has to be done, to ensure effective vaccination and use of this coverage to reach as many children as possible. In this way, the overall goal can be realized.

Supplementary immunization activities (SIA) for Measles Rubella are a way to quickly reduce the number of susceptible in the population. When Measles Rubella vaccine is used for cohorts susceptible to measles and rubella vaccine for other women of childbearing age, SIA provide the opportunity to quickly meet the 2020 objectives. Introduction guideline for planning and implementing supplemental immunization activities for Measles Rubella is intended to assist national immunization programme manager and subnational staff in the planning, organization, implementation and evaluation of Measles Rubella campaign that may be required to meet the objectives.

Introduction of Measles Rubella (MR) vaccine is in line with Global measles Rubella Strategic plan 2012-2020 that stresses the importance of strong routine immunizations, supplemental campaigns, surveillance, outbreak preparedness, case management as well as research towards global elimination of Measles and Rubella. Moreover, it is consistent with the comprehensive Multi-Year Plans (cMYP) for 2010-2015 for Tanzania Mainland and Zanzibar, which clearly outlines the priorities of the programme objectives and strategies for its accomplishment.

The MR introduction guideline outlines key activities to be conducted in preparation for introduction of the vaccine and includes a responsible person for these activities. Moreover it describes advocacy and communication channels to be address prior to introduction of MR vaccine. The guideline stresses the importance of key stakeholders in introduction of MR vaccine and the proposed mechanism for phasing out measles vaccine. In this regards, Tanzania can achieve the goal millennium goal number 4 in improving child survival.

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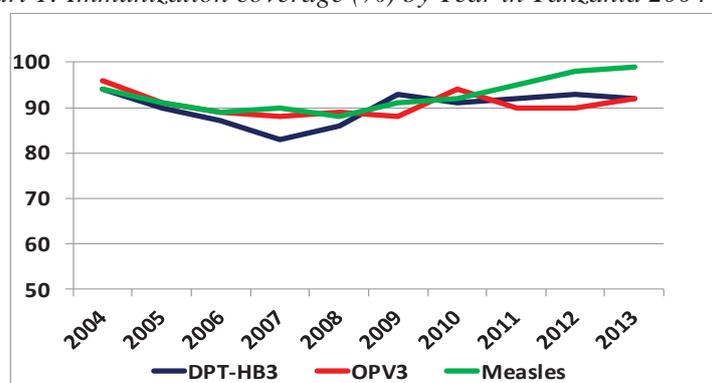
## CHAPTER 1: INTRODUCTION

### 1.1 Routine Immunization services in Tanzania

The Tanzania Development Vision 2025 identifies health as one of the priority sectors. Among its objectives is the achievement of a high quality of life for all Tanzanians. Provision of immunization services is one of the key components in of this aspect. The National Strategy for Growth and Poverty Reduction in Tanzania Mainland (MKUKUTA) and MKUZA in Zanzibar provides the global direction for achievement of the Millennium Development Goals (MDGs).

Immunization services are provided free of charge as part of Primary Health Care (PHC) in all Reproductive and Child Health (RCH) clinics, in both public and private health facilities. A total of 5,500 health facilities (87%) provided immunization services out of 6,321 facilities in 2013. Routine Immunization services coverage has improved since the inception of Universal Child Immunization campaign. Vaccination coverage trend for DPT3 and measles has steadily remained above 80% for the past ten years. Chart 1 shows the trend of administrative coverage of antigens in Tanzania from 2004 to 2013.

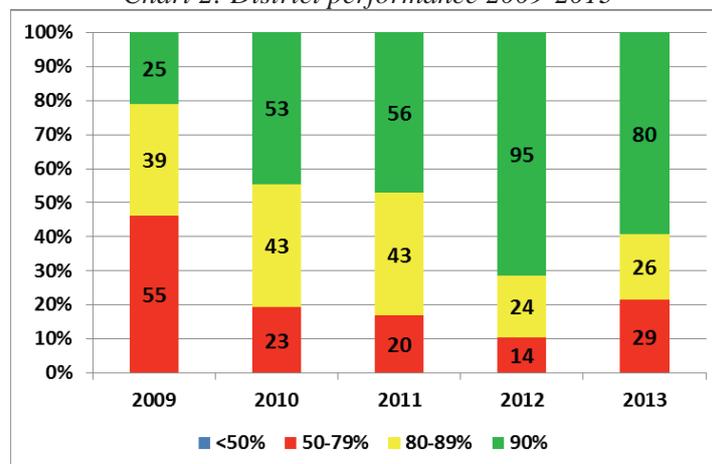
Chart 1: Immunization coverage (%) by Year in Tanzania 2004-2013



Source Tanzania JRF 2011-2013

However there are variations in Regional and Councils performances. Chart 2 shows Councils performance whereby the number of councils with Pentavalent 3 coverage above 90% was steadily increasing up to 2012. Number of districts with Pentavalent 3 below 80% increased from 14 in 2012 to 29 in 2013.

Chart 2: District performance 2009-2013

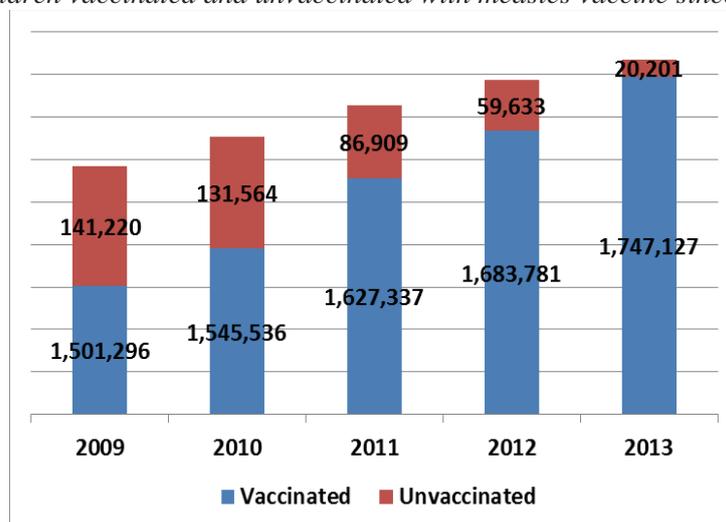


Source Tanzania JRF 2011-2013

## 1.2 Vaccinated and unvaccinated children with Measles vaccine

Tanzania had cumulative of 166,743 unvaccinated children with measles vaccine through routine immunization from 2011 to 2013. This huge number of unvaccinated children puts the country in more risk of occurrence of measles outbreaks. Chart 3 shows the number of vaccinated and unvaccinated children with measles since 2009 to 2013 per year.

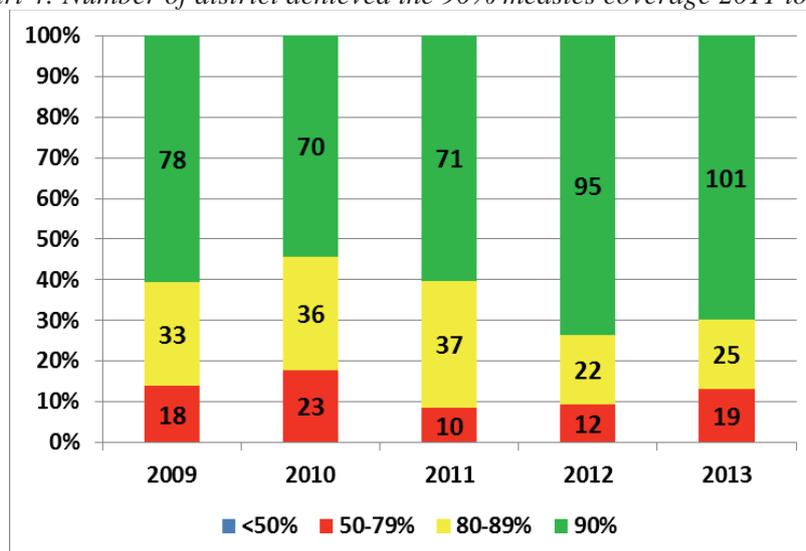
Chart 3: Children vaccinated and unvaccinated with measles vaccine since 2009 to 2013



Source Tanzania JRF 2011-2013

The most recent immunization coverage survey was conducted September 2011 and results indicate that measles routine immunization by crude coverage (card and history) was 95.1%. With respect to measles coverage in depth analysis in the past five years shows there are more than 40 districts consecutively which didn't attain the coverage of 90%. In 2013, 44 districts did not reach the 90% measles coverage as stipulated in chart 4 below.

Chart 4: Number of district achieved the 90% measles coverage 2011 to 2013



Source Tanzania JRF 2011-2013

## 1.3 Overview of Measles in Tanzania

### Measles Immunization history before SIAs

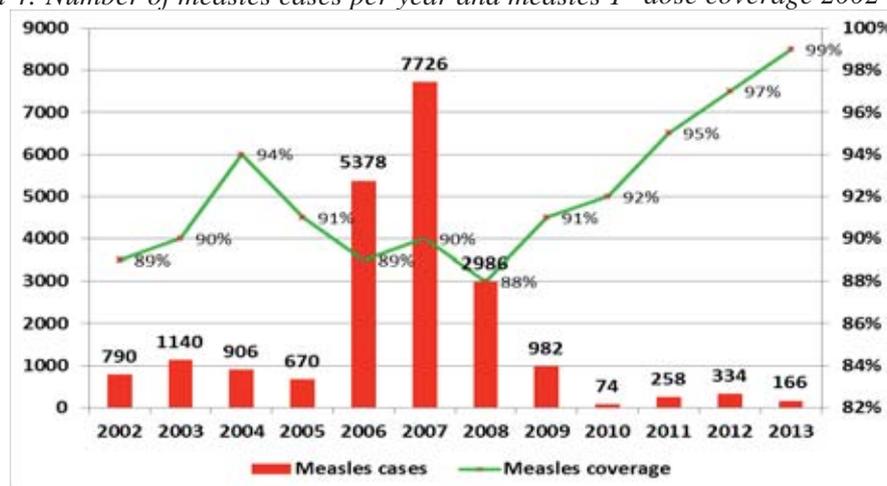
While much progress has been made in reaching children with measles routine immunization and achieving high immunization coverage, measles remains a contributor to childhood illnesses. During the pre-immunization era, measles outbreaks were commonly experienced on annual cyclic. Measles

incidence rates ranged between 100-800 cases /100,000 populations, mainly in the under five year age group with high case fatality rates of more than 25%. When the Expanded Program on Immunization was launched in 1975 measles was one of the vaccines delivered to children at the age of 9 months. Immunization coverage increased from 5% to 50% with corresponding decrease in incidence of measles from 800 to 600/100,000 population. During the Universal Child Immunization (UCI) the immunization coverage rose from below 50% to more than 80% between the periods 1985 through 1989. Measles incidence rate declined from 600/100,000 in 1985 to 42/100,000 in 1989, with an increase in inter epidemic period from 3 to 4 years. The case fatality rate also decreased to less than 5% with a higher proportion of cases occurring in the children above five years. In areas with low coverage, cases occurred in the under five year old with high case fatality rates. After the UCI campaign, coverage started to fall from 80% in 1990 to 72% in 1998.

### Measles epidemiology 2002 to 2010

Since the country conducted the first campaign in 1999 there was a steady decline of measles reported cases. However, one year after the follow up campaign which was conducted country wide in 2005 for children aged 9m to 5yrs unusual increase on the number of cases of measles was observed in 2006 and 2007; the worse scenario was in Dar es Salaam, Pemba and Tanga. After the 2008 follow up campaign cases dropped to less than 1,000 cases. In 2011 we have started experiencing small pockets of outbreaks and sporadic measles cases in several regions but the number remained below 1,000 cases.

Chart 4: Number of measles cases per year and measles 1<sup>st</sup> dose coverage 2002 to 2013



Source Tanzania JRF 2002-2013

### Measles supplemental immunization activities (SIAs)

In 1999, the government of Tanzania began implementation of accelerated measles control strategies to address the low coverage, frequent measles outbreaks, and the mortality associated with measles.

In 1999, a first measles campaign was conducted in 31 Councils in Mainland and 6 Councils in Zanzibar. In September 2000, a second measles mass campaign was held in 4 Councils in Zanzibar and 52 Councils in Mainland of the remaining 83 Councils with the same target age group. In 2001 the target age group was changed to under fifteen years, the campaign was also conducted in 30 Councils in Mainland and 5 Councils in Zanzibar. In 2005 the follow up measles campaign was conducted for children aged 9m to 5yrs countrywide. In 2008 the follow up measles campaign was done to children of 6m to 10yrs.

The latest supplemental immunization activity was conducted in November 2011. All 26 regions in the United Republic of Tanzania were involved in the Integrated Measles follow-up campaign that targeted 6,899,251 children aged 9 months to 59 months. The coverage in this campaign was 96.9%. Several strengths and weakness were noted in this campaign that provide an opportunity for future improvements in current planned campaign

### Measles Case-Based Surveillance

Measles case based surveillance started countrywide at the end of 2002. Table 1 shows the performance of measles case based surveillance indicators from 2007 to 2010.

*Table 1: Performance of measles case based surveillance indicators 2007-2013*

Indicator	2007	2008	2009	2010	2011	2012	2013
Annualized non measles febrile rash illness rate (target >2.0 per 100,000)	1.4	0.2	0.3	2.2	2.4	2.5	2.8
Proportion of districts investigating > suspected case of measles per year (target >80%)	67%	32%	36%	92%	85%	86%	90%

Although the performance at national level is achieved there have been limitations of achieving the surveillance performance targets at sub national level that may have not allowed for prompt detection of low level of transmission of measles. The Virology Laboratory at Muhimbili University of Health and Allied Science handled the testing of all specimens from suspected measles cases in the country since 2007 to 2012 when the testing was shifted to the National Reference Laboratory.

### 1.4 Overview Rubella and Congenital Rubella Syndrome (CRS)

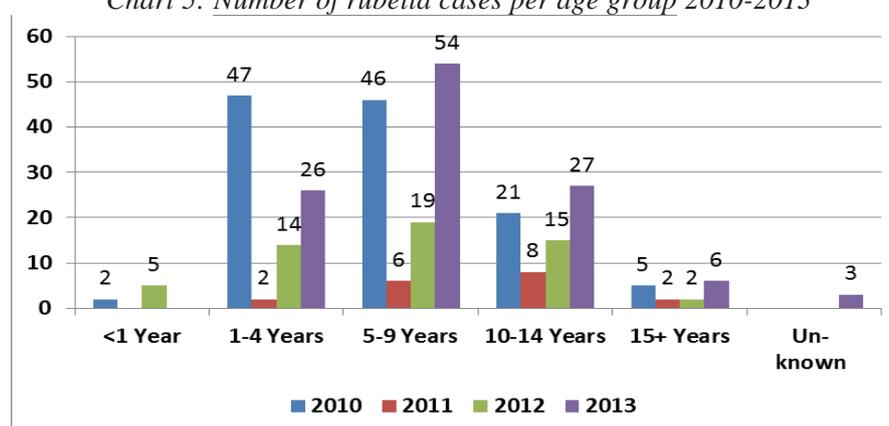
It is estimated that worldwide, more than 100,000 infants are born with CRS each year with an incidence of 0.1 - 0.2 cases per 1000 live births. Following epidemics of rubella, CRS incidence may rise to 1 – 4 cases per 1000 live births.

Rubella virus infection presents with a mild rash and fever. The majority of infections occur during childhood, attack persons of both sexes, and result in life-long immunity. Pregnant women who develop rubella during early pregnancy are likely to experience adverse outcomes of pregnancy collectively known as Congenital Rubella Syndrome (CRS); such as spontaneous abortions, foetal deaths and congenital defects including hearing impairment, heart defects and cataracts. The risk of congenital rubella syndrome (CRS) is highest when rubella infection takes place in the first trimester of pregnancy.

### Rubella surveillance in Tanzania

Tanzania started rubella infection surveillance in 2010 integrated with measles case based surveillance 2010 by testing the non measles febrile rash illness cases when they test IgM negative. By December 2012 a total of 2,780 blood specimens were tested for Rubella and found 9% to be rubella positive. The table below shows the age distribution of rubella cases from 2010 to 2012. More cases are between 1 to 15 years of age confirming that Rubella is mainly a childhood illness in Tanzania.

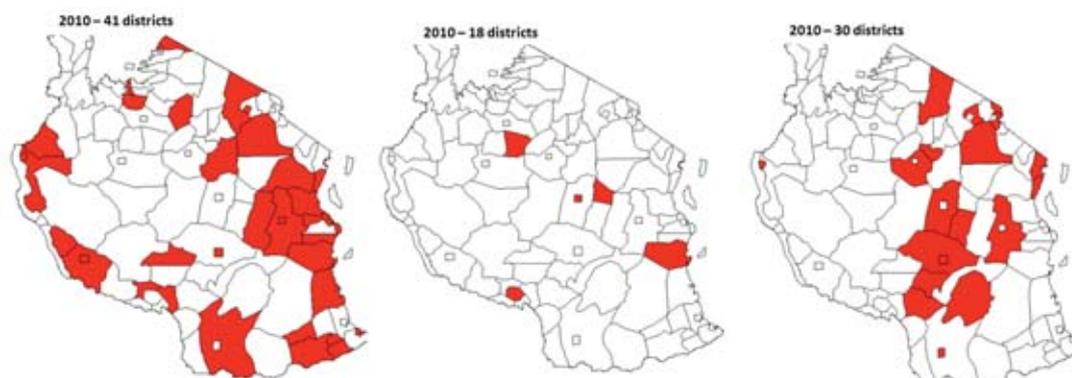
*Chart 5: Number of rubella cases per age group 2010-2013*



Source Tanzania JRF 2010-2013

Rubella is distributed all over the country. Three maps show those districts with confirmed rubella IgM +ve cases from 2010-2013. This indicates that Tanzania has rubella cases although the surveillance is not mainly looking for Rubella cases but a by-product of the measles surveillance.

*Map 1: Distribution of rubella cases in Tanzania 2010-2013*



Study on rubella infection in Mwanza Region in Tanzania conducted Bugando Referral Hospital found that 342 pregnant women tested for rubella antibodies, 317 (92.6%) were positive for anti-rubella IgG indicating the susceptibility of over 7% of women who are not exposed to Rubella infection and are at risk of having babies with CRS in case they are infected with Rubella during pregnancy. Only 1 (0.3%) was positive for IgM. Higher sero-positivity rates were found in the age group of 25–44 years<sup>1</sup>.

#### **Congenital Rubella syndrome (CRS) surveillance in Tanzania**

CRS retrospective review and prospective surveillance has been initiated in New Vaccine Sentinel Surveillance Sites. Establishment of CRS Surveillance helps to provide evidence of CRS in the country and after introduction of RCV will help monitor the trends of CRS cases and indirectly monitoring the impact of the vaccine introduction. These sentinel sites are Muhimbili Medical Centre, Bugando Referral Hospital, KCMC Referral Hospital, Mbeya Referral Hospital, Mnazi Mmoja Zanzibar Referral Hospital and Dodoma Regional Hospital.

These CRS sentinel surveillance conduct investigation of all suspected CRS cases along with appropriate case classification, monthly zero reporting of suspected CRS cases, and generating annual estimates of CRS incidence. Lab testing will be done at National Laboratory. These sentinel site are expected to:

- i. Conduct case-based CRS surveillance in infants 0-11 months.
- ii. Report total number of CRS cases (suspected, clinically confirmed, lab confirmed CRS cases and congenital rubella infections).
- iii. Report number of CRS cases per 1000 live births per year.

<sup>1</sup> Mwambe et al. *BMC Pregnancy and Childbirth* 2014, 14:95

## CHAPTER 2: INTRODUCTION OF RUBELLA VACCINE AS MEASLES RUBELLA VACCINE IN ROUTINE IMMUNIZATION

### 2.1 Global Measles-Rubella Strategic Plan 2012–2020

The United Republic of Tanzania is committed to measles and rubella elimination and endorsed the Measles-Rubella Strategic Plan 2012–2020. This commitment is in line with WHO position paper of 2009 which require member states to reach all children with second doses of measles vaccine through routine immunization programmes. Furthermore, WHO position paper of 2011 on rubella which recommends countries to take opportunity offered by accelerated measles control and elimination activities to introduce Rubella Containing Vaccine (RCV). These measles rubella vaccine delivery strategies will provide an opportunity for synergy and a platform for advanced rubella and CRS elimination.

Global Measles and Rubella Strategic Plan 2012 to 2020 goals are by end 2015

- Reduce global measles mortality by at least 95% compared with 2000 estimates.
- Achieve regional measles and rubella/CRS elimination goals.

The Measles-Rubella Strategic Plan 2012–2020 strategy focuses on the implementation of five core components:

1. Achieve and maintain high levels of population immunity by providing high vaccination coverage with two doses of measles- and rubella-containing vaccines.
2. Monitor disease using effective surveillance, and evaluate programmatic efforts to ensure progress.
3. Develop and maintain outbreak preparedness, respond rapidly to outbreaks and manage cases.
4. Communicate and engage to build public confidence and demand for immunization.
5. Perform the research and development needed to support cost-effective operations and improve vaccination and diagnostic tools.

The WHO position paper recommends conducting a wide age-range catch-up campaign, followed immediately by introduction of MR vaccine in the routine programme. Tanzania is planning to conduct measles rubella campaign from 24<sup>th</sup> to 30<sup>th</sup> September 2014 and immediately follow by introduction measles rubella vaccine in routine immunization. The campaign will target children aged 9 months to 14 years.

### 2.2 Rationale of measles rubella campaign 2014

Despite high measles routine immunization coverage, susceptible individuals will accumulate for the following reasons:

- Un-reached and unvaccinated children with measles vaccine. Some of the councils in Tanzania have measles vaccination coverage rates of below 80% which indicates that there is high number of unvaccinated children.
- Primary vaccine failure given that the measles vaccine is only 85% effective when vaccine is given at 9 months.
- Rubella vaccine is not yet provided in routine immunization in Tanzania

Supplemental immunization activity is therefore necessary to reach unvaccinated children who have never had measles vaccine and to provide another opportunity for a second dose for cases of primary vaccine failure. Either, it reduces the proportion of susceptible individuals in a given population, prevents measles outbreaks and in the context of high routine immunization coverage, eliminates indigenous measles transmission.

The last follow-up vaccination measles campaign was conducted in 2011 targeting children of 9 months to 5 years aiming to sustain reduction in measles morbidity and mortality. With the experience of 2011 follow up campaign that resulted in 95% coverage the proposed catch up measles rubella

campaign in September 2014 targeting wider age group from 9 months to 14 years is expected to have higher coverage.

### 2.3 Immunization Schedule following MR Campaign

The National EPI programme in Tanzania has been providing a number of antigens using static and outreach strategies. Following the MR campaign the vaccine will be tailored in Routine immunization schedule.

*Table 2: Immunization Schedule by September 2014 following MR Campaign*

Age	Vaccine			
At birth	BCG	OPV 0		
6 weeks	OPV 1	DPT-HepB-Hib 1	PCV-13 1	Rota 1
10 weeks	OPV 2	DPT-HepB-Hib 2	PCV-13 2	Rota 2
14 weeks	OPV 3	DPT-HepB-Hib 3	PCV-13 3	
9 months	MRCV 1			
18 months <sup>2</sup>	MRCV 2			

### 2.4 Choice of Measles Rubella Vaccine Formulation

The choice of Measles Rubella vaccine is a freeze dried vaccine in 10 dose vials, lyophilized. The vaccine should be bundled with diluents to reconstitute the vaccine. The vaccine must be discarded after 6 hours or at the end of immunization sessions, whichever comes first.

## CHAPTER 3: INTEGRATED MEASLES RUBELLA CAMPAIGN IN 2014

### 3.1 Overall goal

The overall goal of the campaign is to sustain reduction in measles and rubella morbidity and mortality following the 2011 measles follow-up campaign and prevent importation of wild poliovirus in the country, supplementing children with Vitamin A and Deworming.

### 3.2 Objectives

The national objective for an integrated measles rubella campaign in Tanzania is to:

- Immunise at least 95% of children aged 9 months to under 15 years with measles rubella containing vaccine regardless of their previous immunisation status
- Immunize at least 100% of children aged 0-59 months with tOPV regardless of their previous immunization status
- Supplement 95% of children aged 6 to 59 months with Vitamin A
- Deworming 95% of children aged 12 to 59 months with Mebendazole tablets

### 3.3 Scope of Integrated Campaign, duration and dates of implementation

All 27 regions in the United Republic of Tanzania will be involved in the Integrated Measles Rubella campaign. (Tanzania Mainland and Zanzibar). The activity is planned to be for 7 days starting from 24<sup>th</sup> to 30<sup>th</sup> September 2014

### 3.4 Components of Integrated Measles Rubella Campaign and target population

The Integrated Measles Rubella campaign 2014 will include:

- Vaccination against Measles and Rubella
- Vaccination against polio
- Supplementation of Vitamin A
- Deworming

#### The target age groups for IMRC are:

**Measles Rubella = children aged 9 months to 14 years**  
*Give all children irrespective of previous immunization status*

**tOPV = children aged 0 to 59 months**  
*Give all children irrespective of previous immunization status*

**Vitamin A = 6 to 59 months**

**De-worming tablets = 12 to 59 months**

### 3.5 Target population by intervention

Target population of each intervention are as follows for the whole country;

- Measles Rubella campaign target is 21,159,130 children
- OPV campaign target is 9,488,401 children
- Vitamin A target is 8,539,622 children
- Mebendazole target is 7,116,300 children



#### Remember

*Regional and Council target population of each intervention are available at National Bureau of Statistics Offices at the Regional and Councils Planning Offices.*

### 3.6 Vaccination against polio

Last case of WPV was reported in Tanzania in 30<sup>th</sup> July 1996. In an effort to eradicate polio viruses in Tanzania, several campaigns were conducted in stand alone or in integrated manner together with other interventions like measles vaccination, deworming and vitamin A supplementation. Since wild and circulating polio viruses are not yet eradicated globally, the country is still on the threat of getting importation.

#### Threat of importation of wild polio virus in Tanzania

The recurring circulation of WPV in the Horn of Africa and free movements of people across the borders and lakes makes Tanzania to on the threat. Tanzania ports serves southern part of DRC, Malawi, Zambia, Burundi, Rwanda and Uganda which creates high traffic movement to and from these countries using the major roads in the country. Highways are the major links with DRC, Zambia, Malawi, Burundi, Rwanda, Uganda and Kenya with high traffic movements within the major towns and cities on the border areas.

Tanzania is on high threat of getting importation of WPV because of the following reasons;

- Having high number of OPV3 unvaccinated children in three consecutive years which creates a high number of unprotected children.
- Heavy traffic movements to and from the port to the neighbouring infected countries which are passing in different regions.
- Low AFP surveillance performance in some of the district councils

Efforts should be continued to ensure that the Tanzania community is free from wild and circulating polio virus infection.

#### Polio endgame

The World Health Assembly declared the completion of poliovirus eradication to be a programmatic emergency in May 2012 that lead to development of Polio Eradication and Endgame Strategic Plan 2013-2018. The Endgame Plan calls for the introduction of IPV in 124 OPV-only using countries by the end of 2015 with the aim of maintaining immunity against type 2 polio virus while withdrawing OPV2 globally. Specifically, IPV is introduced for the following reasons.

- To reduce risks.** Once OPV2 is withdrawn globally, IPV will help fill the immunity gap by priming populations against type 2 polio virus should it be reintroduced. A region immunized with IPV would have a lower risk of re-emergence or reintroduction of wild or vaccine-derived type 2 polio virus.
- To interrupt transmission in the case of outbreaks.** Should monovalent OPV2 (mOPV2) be needed to control an outbreak, the immunity levels needed to stop transmission will be easier to reach with mOPV2 compared to use of mOPV2 in a completely unvaccinated population. Thus introducing IPV now could facilitate future outbreak control.
- To hasten eradication.** IPV will boost immunity against poliovirus types 1 and 3 in children who have previously received OPV, which could further hasten the eradication of these two wild viruses

National ICC has endorsed the introduction plan of IPV in Tanzania. The country has applied for GAVI support to introduce IPV in the routine immunization schedule by January 2015.

### 3.7 Vitamin A Supplementation

Vitamin A is a micronutrient, which plays an important role in the following:

- Strengthening the body's resistance to infection
- Protecting the lining of the respiratory and gastrointestinal tract
- Protection of the skin
- Plays a role in vision

Children who are vitamin A deficient suffer an increased risk of death and illnesses particularly from measles and chronic diarrhoea. Of the deaths attributed to measles, 98% occur in developing countries, where vitamin A deficiency is common. It has been known that vitamin A deficiency is the main cause of certain blindness in young children. Studies have shown that improving the vitamin A status of children aged 6-59 months dramatically increased their chance of survival by;

- Reducing chances of dying by 23%
- Reducing deaths due to measles by 50%
- Reducing deaths due to diarrhoea disease by 33%

In areas where Vitamin A deficiency is a problem, many deaths are recorded among infants and under five year olds. Similarly, deaths and blindness due to measles infection are also higher in vitamin A deficient children. In these areas, vitamin A supplements can improve the health of young children and this may contribute to reduction of health care costs. Therefore giving vitamin A supplements where they are required is one of the most cost effective health interventions for reducing infant and child mortality.

### **3.8 Soil-transmitted helminthes**

Soil-transmitted helminthes (STHs), more commonly known as intestinal worms, represent a serious public health problem wherever inadequate sanitation and unhygienic conditions prevail. Three types of worms are the most prevalent and have the most damaging effect on the health of preschool children:

- Roundworms (*Ascaris lumbricoides*),
- Hookworms (*Ancylostoma duodenale* and *Necator americanus*),
- Whipworms (*Trichuris trichiura*).

More than 1.5 billion people or 24% of the world's population are infected with soil-transmitted helminth infections worldwide. Infections are widely distributed in tropical and subtropical areas, with the greatest numbers occurring in sub-Saharan Africa, the Americas, China and East Asia. Over 270 million preschool-age children and over 600 million school-age children live in areas where these parasites are intensively transmitted, and are in need of treatment and preventive interventions.

#### **Rationale for deworming**

Treating children of any age for worms is one of simplest and most cost-effective interventions for improving child's health. Worm-free children have a better nutritional status, grow faster and learn.

The evidence demonstrating how worm infections damage a child's health is unambiguous: worm infections are associated with a significant loss of micronutrients. Roundworms are the most prevalent STH infection in preschool children and cause significant vitamin A mal absorption, which can aggravate malnutrition and anemia rates and contribute to retarded growth. A child's physical fitness and appetite are negatively affected and his or her cognitive performance at school is compromised. The constant and life-long immune activation due to worm infections reduces the body's capacity to resist to other infections.

Preschool children are extremely vulnerable to the deficiencies induced by worm infections: they are in a period of intense physical and mental development and particularly need the vitamins and micro-nutrients that are lost through worm infections.

## CHAPTER 4: PERSONNEL AND RESPONSIBILITY

### 4.1 National Coordination

National Inter-Agency Coordinating Committee (ICC), Ministry of Health and Social Welfare, Tanzania Food and Nutrition Centre and Partners, Regions and Districts are responsible for coordinating, steering the activities and raising funds within and outside the country for implementation of the Integrated MR campaign. The National IVD Technical Working Group with members from Government and Partners has the responsibility from coordinating, planning to implementation of the activities under the guidance of the National ICC.

The coordinating committee at National level will coordinate activities by the other committees from the advocacy and social mobilization, logistics and technical coordinating committees

Membership will have to include members of the ICC and co-opted ICC members to include:

1. Ministry of Health and Social Welfare
  - Immunization and Vaccine Development (IVD)
  - Reproductive Health Unit
2. Health Education Unit
3. Ministry of Gender, Women and Children
4. Faith Based Organizations
5. Red Cross
6. Development Partners (WHO, UNICEF, USAID, CHAI, MCHIP, John Hopkins, Rotary Club, Red cross and others)
7. Civil Society Organization (optional)
8. Ministry of Education
9. Lions Club

The National IVD technical Working Group will have five working groups

Operation Working Group will be responsible for;

- coordination of planning and implementation of the activity
- develop the implementation field guide
- micro planning process and budgeting
- supervising and monitoring the whole operation of the SIAs

Logistics Working Group will be responsible for;

- Estimating the required number of bundled vaccines, cold chain equipment, and transport.
- Ensuring as vaccines are ordered and distribute on time to the regions and districts.
- To develop a logistics plan vaccines to be delivered to the vaccination post and the transport logistics to the final destination.
- Ensuring that the waste generated during the exercise is properly managed as recommended.
- Reviewing the cold chain storage status at all levels and supervising the maintenance and services of all cold chain equipment's before the campaign.
- Develop a contingency plan of cold chain management in each region

Social Mobilization Working Group will be responsible for;

- Secretariate of the National Social Mobilization and Advocacy High level Committee
- Coordinate the National, Regional and District launching
- Community mobilization to create demand for the vaccines and respond in conjunction with the technical team to all questions associated with the vaccines and campaign.
- Development of IEC materials (posters, leaflets etc.); media (jingles, radio and TV spots etc.).
- Support all efforts of advocacy to generate resources from within (Region and Districts) for the SIAs.

Training Working Group will be responsible for all aspects of the SIAs trainings at all levels by and planned activities;

- Reviewing and adapting training documents and operations guide
- Provide and distribute training guidelines and materials
- Supervising and monitoring the trainings to ensure quality of training

Monitoring and Evaluation Working Group will be responsible for;

- Providing and distributing data collection tools such as tally sheets, supervisory checklists, monitoring and evaluation forms / tools
- Monitoring all aspects of the planning and implementation of the exercise
- Planning for the (Pre SIAs supervision, monitoring during and post – SIAs evaluation with assistance for experienced partners.
- Coordinate and facilitate the Coverage Survey

#### **4.2 National Technical Coordinators for the Regions**

Each Region will have a National Technical Coordinator posted from the national level to the Region. The person must be Senior Health Worker preferably with previous experience in the organization and management of immunization activities.

##### **Role and responsibility of National Technical Coordinator**

- Support Regional Team to develop a comprehensive Regional IMC micro plan
- Ensure there are regional maps showing all Councils and Health Facilities service areas
- Ensure the Council level implementation plans are displayed at the Region
- Ensure the availability of vaccines, cold chain and logistics materials
- As part of the Regional team, monitor and supervise implementation of Council Supervisors
- Ensure the personnel involved in the implementation are selected per criteria given
- Ensure the Council Supervisor and Vaccinators are health workers qualified to give injection
- Ensure the recorders are Extension Workers who can easily screen the age of children and record
- Ensure the availability of emergency drugs for AEFI in the region
- Ensure the protocol of handling rumours and providing statements in case AEFI occur to assure the public is discuss in the Regional and District PHC Meetings
- Monitoring and auditing all Adverse Events Following Immunisation(AEFI)
- Ensure the waste management plan is clear to all Council Supervisors and monitor the waste management at the implementation level
- Ensure data collection and compilation is done inclusive of daily report and shared among stakeholders and feedback provided using the data; use the administrative reports to ensure logistics supply is adjusted
- Support regional team to manage properly the financial resources provided for implementation of IMC
- Support Regional Team to conduct the Regional level stakeholders meeting to discuss on IMC

#### **4.3 Region Health Management Team**

Region Health Management Team supported by other immunization stakeholders based in the Region their main responsibility is to develop regional macro plan, coordinate, supervise and monitor the planning and management of the implementation in the region. The Regional Technical Team will work under guidance of the Regional Commissioner and Regional Administrative Secretary through Regional Primary Care Committee.

#### **Composition of Region Technical Team**

1. Regional Medical Officer- Chairperson
2. Regional Administrative Secretary
3. Regional Immunization and Vaccine Officer
4. Regional Health Secretary
5. Regional RCH Coordinator
6. Regional Nursing Officer
7. Regional Health Officer
8. Regional Pharmacist
9. Regional Dental Surgeon
10. Regional Bureau of Statistics
11. Regional Nutrition Officer
12. Regional Education Officer

#### **4.4 Regional Technical Coordinators**

Each Council will have two Regional Technical Coordinators from the Regional Technical Team posted from the Regional level to the Council. One must be a Senior Health Workers in the region or Tutors of schools of health technology/ nursing/ midwifery/ allied health training institutions in the region.

#### **Role and responsibility of Regional Technical Coordinator**

- Support Council Team to develop the comprehensive Council IMC micro plan
- Support Council Team to conduct the Council level stakeholders meeting to discuss on IMC
- Ensure there are ***Council maps*** showing all the Health Facility service areas, villages/ streets, vaccination post fixed and temporary, roads with distance and population.
- Ensure the Health Facility service area level implementation plans are displayed at the Council Ensure the personnel involved in the implementation are selected per criteria given
- Ensure the Council Supervisor and vaccinators are health workers qualified to give injection
- Ensure the recorders are Extension Workers who can easily screen the age of children and record
- As part of the Council team, monitor and supervise implementation of Local Supervisors and Vaccination Teams
- Ensure the availability of vaccines, cold chain and logistics materials
- Ensure the protocol of handling rumours and providing statements in case AEFI occur to assure the public is discuss in the District PHC Meetings
- Ensure the availability of emergency drugs for AEFI
- Monitoring and auditing all AEFI
- Ensure the waste management plan is clear to all Local Supervisors and Vaccination Teams and monitor the waste management at the implementation level
- Data collection and compilation including sharing of reports to next higher level on daily basis
- Support Council team to manage properly the financial resources provided for implementation of IMC

#### **4.5 Council Health Management Team**

Council Health Management team supported by other immunization stakeholders based in the District Council their main responsibility is to develop council micro plan, coordinate, supervise and monitor the planning and management of the implementation in the council. The District Technical Team will work under guidance of the District Commissioner and District Executive Director through District Primary Care Committee.

#### **Composition of District Technical Team**

1. District Medical Officer - Chairperson
2. District Immunization and Vaccine Officer
3. District Health Secretary
4. District RCH Coordinator
5. District Nursing Officer
6. District Health Officer
7. District Pharmacist
8. District Planning officer
9. District Educational Officer
10. District Nutritional Officer
11. District Social Welfare Officer

#### **4.6 Council Supervisor**

A cluster of vaccination post depending on the accessibility and terrain will have a Council Supervisor posted from the Council level. Such persons must be Senior Health Workers in the Council.

#### **Role and responsibility of Council Supervisor**

- Support the Health Facility in charge to conduct the stakeholders meeting to discuss on IMC
- Supervise Vaccination Post Supervisor and Community Leaders to conduct house to house mobilization prior to implementation
- Ensure there is a ***Health Facility service area map*** showing all the villages, settlements/streets, vaccination post, roads and population
- Ensure the Posts daily implementation plans are displayed at the Health Facility (movement of teams for each day)
- Ensure the hard to reach areas and special population are reached
- Ensure the Post vaccinators are health workers qualified to give injection
- Ensure the recorders are Extension Workers who can easily screen the age of children and record
- Ensure the availability of vaccines, cold chain and logistics materials
- Ensure the availability of emergency drugs for AEFI
- Monitoring and auditing all AEFI
- Ensure the waste management plan is clear to all Vaccination Teams and monitor the waste management at the ward level
- Monitor the collection of the waste (safety boxes) from the wards to the burn and bury areas every day.
- Monitoring and supervision of the implementation
- Data collection and compilation and sharing of daily report to the next higher level
- To attend daily implementation meetings at District level
- Ensure there is proper supervision and administration of the financial resources

#### **4.7 Vaccination Post Team**

Each Vaccination Post Team will be under the supervision and coordination of one senior Health Worker as a Post Supervisor.

### Role and responsibility of Vaccination Post Team Supervisor

- Responsible with immunization activities in the Post service area
- Coordinate the post activities
- Ensure house to house mobilization is done prior implementation within the post service area.
- Ensure the volunteers are mature and respected persons selected within the service area who can influence change in the community
- Ensure the post is functioning according to the vaccination post implementation plan
- Ensure all eligible children are given Measles and OPV regardless of the vaccination status
- Ensure the availability of vaccine, cold chain and logistics materials
- Ensure the availability of emergency AEFI drug kit
- Monitor, manage and audit all AEFI cases and report to the Council Supervisor immediate
- Data collection, compilation and submission to the Council Supervisor on daily basis
- Collect the safety boxes from the post to the designated burn areas every day.
- Monitoring and supervision of the implementation
- Monitor the waste management issues in the out post

The following are the personnel in the Vaccination Post team

### Composition of a Post team

Personnel	Total Number
Vaccinators	2
Recorder	2
Community Leader	1

This composition of the team is designed to allow the vaccinators the optimum environment to be able to vaccinate an acceptable number of children and allows for greater flexibility in responding to the situation in the field.

Vaccinator must be Health Worker qualified to give injection selected by the Council Team.



#### Remember

- Don't post two qualified and experienced health workers in the same post
- Qualified and experienced health workers be assigned to give injection

Recorder must be:

- Extension Worker who can easily verify the age of the children and record properly
- Endorsed by Council Team
- Community Leaders must be selected by community within post service area



#### Remember – Team selection

- Poor team selection is a major problem of the failure in immunization activities
- Vaccinators must be health workers who can give injection.
- Recorder must be extension workers
- Community Leader must be a respectable person selected by community

## ROLE OF THE PERSONNEL AT THE IMMUNIZATION POST

### VACCINATORS

#### **VACCINATION TEAM**

The team consists of 2 persons, qualified to administer injections and other interventions

1. Dilute the vaccine with appropriate diluents and record vials used
2. Prepare the AD syringes for administration
3. Ensure the vaccination area remains safe and clean
4. Ensure correct storage of vaccine
5. Vaccinate the child/adolescent
6. Ensure procedure safety and injection safety
7. Monitor and respond to reactions
8. Inform the caretakers on possible side effects of vaccination
9. Ensure Vitamin A and Mebendazole are administered according to age

### RECORDER

#### **RECORDER**

A Teacher or Extension Worker

1. Check that the person is within the target age group.
2. Tally after each intervention

### COMMUNITY LEADER

#### **COMMUNITY LEADER**

A person selected from the Community that is to be covered by the vaccination team.

1. Assist in the setting up of the vaccination point each day.
2. Maintain order in the waiting zones.
3. Ensure client flow
4. Before and during the campaign continue to mobilize communities.
5. Line list all institutions with children under 15 years and make appointment for vaccination team to visit the institution within the 3 days of implementation
6. To do house to house mobilization prior to the campaign

## CHAPTER 5: PLANNING OF INTERGRATED MEASLES RUBELLA CAMPAIGN

### 5.1 National level planning

At national level planning for IMRC includes the following elements:

- Obtaining endorsement from Inter-Agency Coordinating Committee (ICC), stakeholders and policy makers
- Soliciting high-level political commitment
- Establishing appropriate inter-sectorial sub-committees
- Resource mobilisation
- Forecasting and developing a plan of action, that specifies the target population, target area, required supplies and timelines for the various activities.
- Developing training materials/guidelines
- Advocacy and Social Mobilization
- Developing logistics and data management tools
- Organising Region and Council level micro-planning and training
- Procurement and distribution of vaccines and other supplies
- Monitoring and Evaluation

### 5.2 Regional level planning

At regional level planning for IMRC will involve;

- Development of macro plans and plan of action for the region
- Soliciting Regional Administrative and Stakeholders commitment
- Support Councils to conduct sensitization, advocacy and social mobilization in their respective areas
- Distribution of vaccines and other supplies to the councils
- Work closely with councils in the development of their micro plans
- Support the councils in the resource mobilization in bridging funding gap if any through their councils.
- Collect and collate Council micro plans to form one region plan
- Support in coordinating supervision & monitoring plan of the lower levels

The Regional macro planning process will use the following tool:

1. Target population (*See Annex 1a*)
2. Health facilities and villages (*See Annex 1b*)
3. Personnel required per Council (*See Annex 1c*)
4. Bundled Vaccines and supplies (*See Annex 1d*)
5. Data management tools (*See Annex 1e*)
6. Cold chain management(*See Annex 1f*)
7. Waste management (*See Annex 1g*)
8. Transport management (*See Annex 1h*)

### 5.3 Council Operational Micro-planning

#### Objective of council operational micro planning

- To ensure accurate implementation plan including daily work plan for vaccination teams that enable to reach ALL villages/ settlements during the implementation period
- To ensure appropriate selection of the vaccination posts sites of (fixed and temporary teams)
- To ensure community leaders are well sensitized and involved in the planning immunization campaign

#### Issues to be considered in micro planning

- The quality of the campaign depends on the realistic and practical micro plan
- The accessibility to reach the community take in account geographical and socio cultural issues
- Personnel to undertake the activity

- Availability of other resources
- Micro plan will differ place to place depending of many factors

### **Components of council operational micro planning**

The council operational micro-plan has various components and clarifies *who* is responsible for *what* tasks as well as *when* and *where* these tasks should be carried out.

1. Determine the catchment population, villages and health facility for each vaccination site. (See Annex 2a)
2. Determine the strategy (fixed or temporary) to reach all children in the catchment area
3. Determine where to put the vaccination posts
4. Determine the human resources needed for the Council. (See Annex 2b)
5. Determine the quantity of vaccines and supplies needed (See Annex 2c)
6. Determine the cold chain needs for the campaign (See Annex 2e)
7. Determine the training needs for the vaccination team, supervisors, and social mobilization
8. Develop the waste management plan (See Annex 2f)
9. Determine the transportation needs for the campaign (See Annex 2g)
10. Develop a distribution plan for all campaign materials-data management tools (See Annex 2d)
11. Develop a social mobilization plan for the Council.
12. Develop Council budget for campaign.
13. Determine the resource gaps and develop a plan to meet them.

### **5.4 Steps for Council Operational Micro planning**

Council micro-planning is critical to the successful implementation of the IMC. The following are the initial steps to conduct the Council operational micro planning

Step 1: Have planning meeting at the Council with the Health Facility in-charges and

- List all health facilities in the Councils with and without routine immunization services either public, parastatal, FBO and private
- Define as much as practicable the catchment area of each listed health facility
- Identify the number of Health Workers who can give injection in the Council and their location
- List of all villages with target population in each health facility catchment area

Step 2: Draw a map of the Council. The map should contain all important features of the Council and mark the following information on the map

- All health facilities
- Villages, settlements and towns
- Total population and target population of each health facility
- All known high risk or priority areas
- Main roads in the Council
- Geographical landmarks (rivers, streams, mountains).

Step 3: Demarcate on the map the catchment area for each health facility which will be involved in the campaign by day of the SIAs? (Movement plan integrated for vaccination)

- Show the areas where fixed and temporary sessions will be done

### **5.5 Health Facility operational micro planning**

Health Facility operational micro-planning is critical and essential to the successful implementation of the IMC. Micro-planning at Health facility level should be managed by Council team Supervisor, Health Facility in charge in collaboration with community leaders.

The information listed below should be collected for each health facility service area.

- Total population and target population of health catchment area
- List of villages and settlements either permanent or temporary with estimated target population
- Number and locations of churches and mosques

- Number and location of markets
- Estimated distance of the village/settlement to the health facility
- Number of available qualified health workers who can give injection
- Cold chain situation: number of cold chain equipment and volume of freezing capacity. Gaps and options available to support freezing ice packs( e.g. private sector even the Community Leaders)
- Hard to reach areas with their local suggested solutions
- List all areas where routine immunization outreach are conducted
- List all known high risk or priority areas

### 5.6 Determining the number of posts required in Health Facility service area

This is “important part” of the Health Facility micro planning. By now you know exactly

- Target population of each village or street
- Geographical situation
- Socio cultural factors
- Number of personnel who can give injection and other related issues

The estimates of the number of vaccination posts services area are based on the children who will be given measles immunization. Each vaccination post service area will have one vaccination team.

**One vaccination post service area = One vaccination team**

Each vaccination team can vaccinate minimum average of 300 children in the urban/densely populated and 250 children in the rural/sparse population per day in optimum conditions in Tanzania.

**One vaccination team will have 2 vaccinators**

Urban/dense Population: 300 vaccinations/ day  
**1500 vaccinations/ 5 days**

Rural/sparse Population: 250 vaccinations/ day  
**1250 vaccinations/ 5 days**

The number of posts required is the target population (urban or rural) divided by the number of vaccinations per 5 days.

**Example for calculations**

*Example 1:* Urban target population of 6000 **6000 / 1500 = 4 Teams**

*Example 2:* Rural target population of 3750 **3750 / 1250 = 3 Teams**

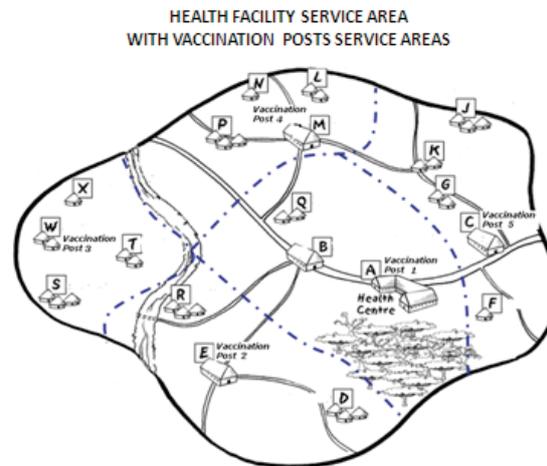
**Total number of vaccination post required for the health facility services area = 7 Teams**

The 6<sup>th</sup> and 7<sup>th</sup> days will be specifically to conduct mop up for areas which are not covered and where the rapid assessment shows that mobilization need to be done and children vaccinated. All health facilities and fixed posts must continue to vaccinate on the 6<sup>th</sup> and 7<sup>th</sup> day.

## 5.7 Draw Health Facility service map showing:

The map should be simple but informative:

- Show the boundaries of the service area
- Show all villages/settlements within the service area
- Include all key geographic features/landmarks on the map (rivers, mountains, major roads, etc)
- Indicate the estimated population/target population for each village/settlement
- Show distances of villages/settlements from Health Facilities
- Indicate areas where mobile- temporary posts are done
- All known high risk or priority areas
- Show clearly the vaccination post service areas
- Include movement plan of the vaccination team to avoid grey areas that are left out



### Remember

- Each Health Facility must have a map showing clearly the Post service areas.
- Each Post service area must be clear to Community Leader for accountability during implementation.

## 5.8 Vaccination Post service area

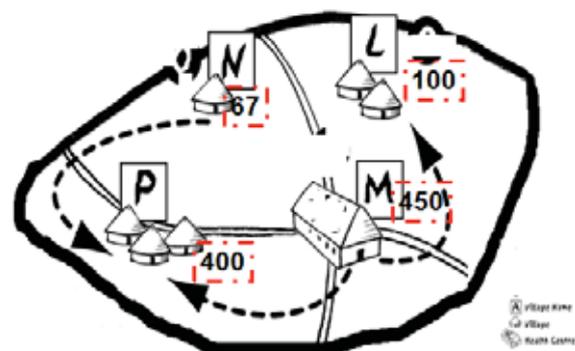
Vaccination Post Campaign service area is a specified area with number of villages/settlements or streets within the Health Facility service area.

Each Post Service area must have map showing clearly the villages, settlements and streets even the sparsely populated communities and hard-to-reach areas. A vaccination post service area must not overlap to other vaccination post area. Each post will have their own service areas depending on the population and terrain and socio-cultural factors.

### Key issues to consider in the vaccination post area micro planning include;

- How many settlements are in the vaccination post area with target population
- Which strategy to be used in this vaccination post area (fixed or temporary)
- Where to position the vaccination post
- How to get the recorders and community leaders

To demarcate the service areas, detailed micro plans and social mapping of the area must be used. These service areas must be clear to the community leaders for easy accountability during implementation.



## 5.9 Determining the strategies for implementation in seven days

In the Fixed vaccination posts immunization will be provided at these sites for either the whole duration of the campaign or partially depending on the population density and be located either in the Health facilities, schools, government offices, mosques / churches, bus terminals, roadblocks and market areas.

### Example of mobile temporary team implementation plan

Mobile temporary posts can be used in the less densely settlements, sparsely populated areas, and distance too hard to reach areas, underserved areas, and geographical location and socio cultural factors. Each mobile-temporary team must have a clear implementation plan for five days showing exactly the place to be visited, day and time of implementation.

	Areas of vaccination	Number of children	Remarks
Day 1 – 2	Dihimba Primary School	450	Post to be at Primary school
Day 3 morning	Dihimba Secondary School	67	Post to be at Secondary school
Day 3-evening	Dihimba B	100	Post to be at settlement leader house
Day 4	Dihimba A	200	Post to be at village office
Day 5	Mpondomo B	280	Post to be at health centre
Day 6	Mop-up		All children missed-Post be at primary school
Day 7	Mop up		



#### Remember

- In sparsely and hard to reach communities post team are expected to move when necessary (when settlement is fully covered)*
- Community leaders must be fully involved in the planning process and know exactly the time and date of arrival of the team in the communities*

### 5.10 Characteristics of a well-functioning fixed post

These are some basic characteristics of well-functioning fixed post.

- Efficient client flow through the post:
  - Design the post for efficient flow of clients and avoid “bottle-necks” such as overcrowding, confusion and very long waiting time (i.e. mothers/guardians waiting for long before being attended).
  - Design an entry-exit one-way traffic flow through the post.
- Adequate space for the vaccination team:
  - This enables the vaccination team to function efficiently and safely;
  - Teams working in the permanent fixed posts should be situated away from routine activities.
- Adequate Crowd Control ensuring that the registration desk is not becoming overburdened.
- Have a clear sign indicating the on-going event (poster, flag or banner)

### 5.11 Criteria for establishing vaccination posts

- The vaccination post must be located close to the targeted communities such as schools, market areas, government building and there has to be free accessibility.
- The selected room should have adequate spaces to accommodate all events

The following can be considered for establishing a vaccination post:

- All Health Facilities providing routine immunization
- Other Government Health Facilities not providing routine immunization
- Private Health Facilities
  - With minimum of two health workers who can give injection
  - Ready to be opened throughout the period of implementation including weekends.
  - Trained staff must be available throughout the period of implementation including weekends.

- To have a designated room for IMC other than the usual injection room.
- Must be accessible to all communities.

### 5.12 Necessary items for a vaccination post

A vaccination post whether temporarily or fixed should have at least the following items:

- At least two tables and chairs that can be borrowed from the community
- Improvised containers
- Safety boxes and water buckets
- Vaccine carriers
- Two frozen ice packs each day (if they will move from one point to another they will need extra for the travelling days )
- Adequate vaccines, injection materials and related supplies according to the target population
- Adequate number of monitoring forms
- SIAs marker pens
- Emergency drugs for severe AEFI

### 5.13 Sequence of events at the vaccination post

The sequence of events and client flow recommended is as follows.

#### Parents and children wait in the allocated areas.

It is important that the Community Leader in charge of crowd control ensure that the flow through the vaccination post is maintained and bottlenecks are avoided. In addition they should inform the waiting parents of any problems or delays. In case the same door is used for entry and exit it is advised the exercise should be done outdoor under shade in a sequential manner

#### Table 1: Community Leader

Community Leader welcomes the parents/guardian and child and verifies that the child is within the target age group of below 15 years.

- Parents/guardian and children wait in the allocated areas.
- Ensure the flow through post is maintained and bottlenecks are avoided.

#### Table 2: tOPV, Vitamin A and Mebendazole

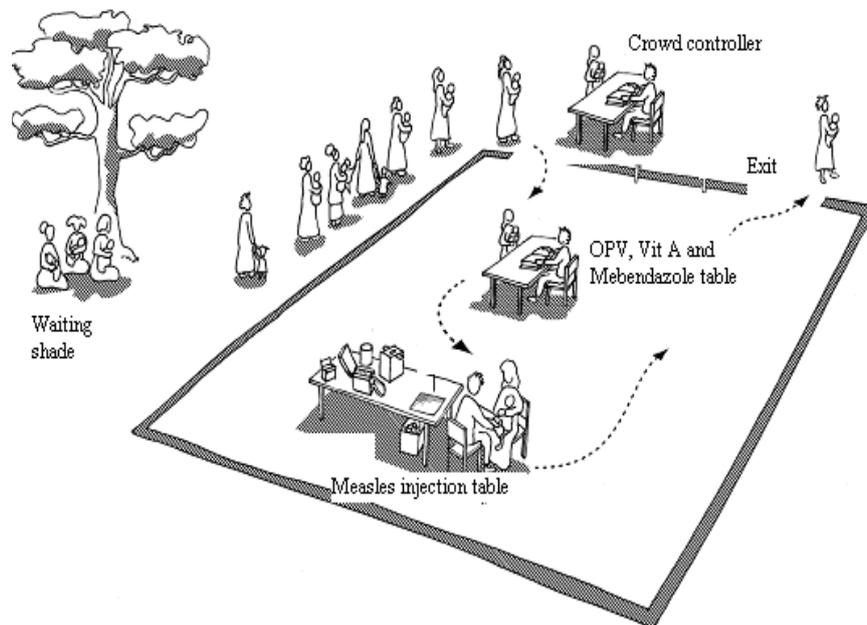
Table 2 will be specific to give tOPV, Vitamin A and Mebendazole.

1. If the child is above 5 years send the child to Table 3
2. If the child is below six months give tOPV, thank the mother and send him/her home
3. If the child is above 6 months and under 5 years:
  - Give Vitamin A
  - Give tOPV
  - Give Mebendazole (**If the child is above 1 year and under 5 years**)
  - Send the child to table 3
4. Take the records in specified tally sheets for OPV, Vitamin A and Mebendazole given per child

#### Table 3: Measles Rubella Vaccination

Table 3 will be specific to give Measles Rubella Vaccination

- If the child is aged 9 months to 15 years give 0.5mls of measles vaccine injection by subcutaneous route in the **upper left arm**.
- Tally the measles rubella dose given to the child immediately and mark the child with permanent marker on the bottom of left little nail touching or overlapping the skin.



#### 5.14 At the end of the day

- Each vaccination team sums up their tally sheets and counts the number of vials used or wasted.
- Ensure that all safety boxes and buckets with used cotton wool/swabs are collected for burn and bury.
- The buckets need to be returned to the posts for the following day's session.
- Ensure the bin is emptied and waste burnt.
- Return the unused vaccine vials to the health facility, as well as other equipment and utensils.
- Clean the tables and surroundings of the post.

## CHAPTER 6: ESTIMATING FOR RESOURCES AND LOGISTICS FOR IMPLEMENTATION

### 6.1 Estimating vaccines and other interventions requirements

Estimating the resources and logistics for implementing the mass campaigns are done with expectations of 100% coverage, the formulas given in this guide are only specific for campaigns and not to be used for routine immunization.

The principle of forecasting and ordering of MR vaccines to be used in routine immunization (RI) will follow the usual ordering of vaccines used in RI.

The formula used to calculate the number of vaccines and other interventions during IMRC is with expectation of 100% coverage. For supplemental immunization activities the wastage rate is estimated to 10% and buffer stock of 5%

#### Measles Rubella vaccine

Target population x 1.11 (wastage factor) = number of doses of measles rubella vaccine

*Example:* Target population: 27,413 x 1.11 = 30,429 doses

MR vaccine is supplied in 10 dose vials therefore divide the number of doses required by 10

*Example:* 30,429 doses / 10 = 3,043 vials

#### Tri - Oral Polio Vaccine (tOPV)

Target population x 1.11 (wastage factor) = number of doses of tOPV

*Example:* Target population: 32,250 x 1.11 = 35,796 doses

tOPV is supplied in 20 dose vials therefore divide the number of doses required by 20

*Example:* 35,796 doses / 20 = 1,790 vials

#### Vitamin A

Target population A (6-11 months) x 1.11 (wastage factor) = number of vitamin A doses of 100,000 I.U.

*Example:* Target population: 12,900 x 1.11 = 14,319 doses of 100,000 I.U.

Vitamin A is supplied in 1 dose capsules therefore divide the number of doses required by 1

*Example:* 14,319 doses / 1 = 14,319 capsules

Target population B (12-59 months) x 1.11 (wastage factor) = number of vitamin A doses of 200,000 I.U.

*Example:* Target population: 22,880 x 1.11 = 25,397 doses

Vitamin A is supplied in 1 dose capsules therefore divide the number of doses required by 1

*Example:* 25,387 doses / 1 = 25,397 capsules

*Remember to request A and B above separately as dosages are different due to age groups*

#### Mebendazole

Target population (12-59 months) x 1.11 (wastage factor) = number of Mebendazole tablets of 500 mg.

*Example:* Target population: 22,880 x 1.11 = 25,397 doses

Mebendazole is supplied in 1 dose tablet therefore divide the number of doses required by 1

*Example:* 25,397 doses / 1 = 25,397 tablets.

## 6.2 Estimating injection materials and other supplies requirements.

### Auto-disable syringes (0.5 ml) for injection

One child- one syringe- one needle should strictly be followed in measles rubella campaign. For calculation purposes, the same wastage factor is used for vaccines and syringes. The number of AD syringes equals number of doses of measles rubella vaccine calculated above.

Total number of A-D syringes, 0.5 ml required = Same (round up) number of doses for MR campaign

Example 78,000 doses of measles rubella vaccine = 78,000 auto-disable syringes 0.5 ml

### 5.0 ml dilution syringes and needles for mixing

Syringes of 5.0 ml with Re-use prevention feature (RUP) will be used to reconstitute the Measles Rubella vaccine. The following formula is used to calculate the required number of reconstitution syringes and needles.

Total number of 10-dose vials of measles rubella vaccine = total number of 5.0 ml syringes and needles (RUP) required.

Example: 7,800 vials = 7,800 5 ml syringes and needles with RUP.

### Safety boxes

One safety box of 5 litres can hold 100 syringes and needles. Therefore for each Council, health facility and vaccination post, adding the number of AD – syringes (7.2.1) plus the number of reconstitution syringes with RUP (7.2.2) and dividing by 100 plus 15% wastage rate gives the number of safety boxes required at that level.



#### Remember

*Safety boxes should be burnt at end of EACH day (even if not full) which bring wastage factor to 1.15.*

The following formula is used to calculate the number of safety boxes required

$(\text{Number of auto-disable} + \text{Dilution syringes}) / 100 \times 1.15$  wastage factor  
(1 safety box can hold 100 used syringes and needles)

$(78,000 \text{ A-Ds} + 7,800 \text{ Dilution syringes}) / 100 \times 1.15 = 988$  Safety boxes

### Marker Pens

Every child vaccinated with measles rubella will be marked on the base of little finger nail of the left hand. The following formula is used to calculate the number of marker pens required

$(\text{Number of children to be vaccinated} / 350) \times 1.05$  buffer stock = marker pens required  
1 marker pen is sufficient to mark 350 children

Example:  $(79,743 \text{ children to be vaccinated with Measles Rubella} / 350) \times 1.05 = 240$  marker pens

## 6.3 Calculating cold boxes, vaccine carrier and cold pack requirements

Health facilities are the centres for storage, distribution and collection of vaccines and related supplies for the IMRC on daily basis. Sustaining effective cold chain at this level is important and should include the following considerations during campaign:

- Location of supplies storage/take off points in each post.

- A minimum of one cold box in functional condition (check lid sealing) for cold packs and vaccines/diluents is required in the hard to reach areas where vaccination teams will spend nights implementing.
- One vaccine carrier per post.
- At least 12 frozen cold packs/cool water-packs of 0.6 ltr for each cold box

#### 6.4 Cold Chain Space requirements

The following two calculations are needed at each level to verify whether there is sufficient cold space for IMRC vaccines:

- **Calculate the total cold chain space available**  
Obtain an inventory of the functional cold chain equipment available.
- **Subtract space used for routine immunization**  
To calculate the amount of cold chain space available for vaccine supplies for campaigns, subtract the estimated amount of space used for routine immunization services from the total space available.

If there are problems of inadequate space at all levels the following options should be applied:

- **Use a “fast chain”.** This means sending vaccine with plenty of frozen packs rapidly through the level with inadequate cold space to reach the level where space is adequate.
- **Strategically time deliver/collection quantities for routine immunization vaccines.**  
Distribution of routine vaccines should be portioned and the remaining delivered soon after implementation of campaign if the cold storage space is not adequate at Council or some health facilities.



#### Remember

- Vaccines and diluent at the health facility level should be kept at temperature range of +2°C - +8°C.
- Do not use measles rubella vaccine after six hours of reconstitutions
- VVM on vials should not reach discard point

#### 6.5 Maintenance and repair of the cold chain system

- Ensure that the cold chain is working both at the region/zone, Council and health facilities level and during the campaign.
- At region/zone and Council with freezers measles rubella and tOPV vaccines should be stored at temperature between -15°C to -25°C
- Ensure that the refrigerators are maintaining temperatures between +2°C to +8°C at all levels
- Do not keep or store diluents in freezer space or compartment.
- Ensure that the batteries for the solar refrigerators are in good condition and the solar panels are clean.
- Ensure that there are enough usable cold boxes, vaccine carriers and ice packs/cool water packs.
- Observe the VVM status of the vaccines.

**The vaccine vial monitor says...**

	✓ <b>If the expiry date has not passed, USE the vaccine</b>
	✓ <b>If the expiry date has not passed, USE the vaccine</b>
	✗ <b>Discard point: DO NOT use the vaccine.</b>
	✗ <b>Beyond the discard point: DO NOT use the vaccine.</b>



#### Remember

*Do not stop immunization because of lack of cold packs if VVM has not reached discard point stage 3*

## 6.6 Planning transport requirements

Transport is needed at all levels before, during and after the campaign for the following purposes:

- Transportation of vaccines, cold chain equipment such as cold boxes, ice packs/cool water packs, vaccine carriers, injection materials and other supplies from the Councils to the posts and back after the campaign.
- Distribution of social mobilization and monitoring materials.
- Transport of personnel for IMRC teams (i.e. to fixed posts, mobile in hard to reach communities)
- Transport of personnel for monitoring and supervision of the IMRC
- Transportation of waste from vaccination points to incineration or burn and bury points where applicable.

## 6.7 Distribution of Vaccine and other supplies

A plan should be made for distribution of vaccine/injection equipment and other supplies at each level. Region level to Council, from where distribution goes out to the health facilities and the posts.

The plan should consider the following:

- Number of kilometres round trip for distribution
- Duration of time required for distribution
- Mode of transport for distribution of vaccines and other interventions
- Personnel responsible
- Accessibility of the area

Council Teams should use supervisory site visits for other aspects of the campaigns (training, social mobilization, cold chain assessment) to deliver other materials necessary for the campaign (tally sheets, social mobilization materials, supplementary cold chain equipment, training materials, injection materials).

Delivering vaccines for the campaign should be strategically timed when stocks for routine immunization vaccines are low.



### Remember

*Vaccines are very sensitive to heat, distribution to health facilities should be done close to implementation days*

## 6.8 Switching from Measles Vaccine to Measles Rubella Vaccine

Measles vaccine will continue to be used until a day before MR campaign. During the campaign, MR vaccine will be used and immediately after the campaign, MR vaccine will continue to be used in routine immunization.

But health facilities which will still have the measles vaccines after the campaign will have to continue using the measles vaccines until the stock is finished, and thereafter continue to use MR vaccines.



### Remember

*Regions and Councils should make estimate of measles rubella vaccines to last up to the campaign day.*

## CHAPTER 7: INTERVENTION SAFETY

### 7.1 Measles Rubella Vaccine

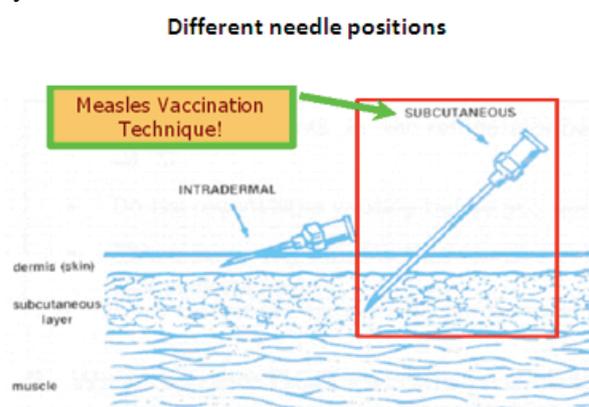
Measles Rubella vaccine is a combination of measles and rubella antigens. It is a live attenuated virus and freeze –dried (lyophilized) vaccine. The vaccine is safe highly effective. It is sensitive to sunlight hence it is kept in a coloured glass vials. Following reconstitution, the vaccine must be stored in the temperature between +2°C to + 8°C and used within 6 hours.

#### Reconstituting and administering the Measles Rubella Vaccine

Reconstituting and administering the measles rubella vaccine are essential tasks. The steps for these tasks are as hereunder:

#### Reconstituting Measles Rubella Vaccine

- Vaccine reconstitution should be performed by a health worker and should only be reconstituted with the diluents provided by the same manufacturer.
- Always use a new, sterile, syringe and needle with RUP to reconstitute each vial.
- Diluents should have the same temperature
- Reconstituted vaccine **MUST** be discarded immediately if:
  - o Sterile procedures have not been fully observed;
  - o There is any suspicion that the opened vial has been contaminated;
  - o There is visible evidence of contamination, e.g. a change in appearance, floating particles or the cold chain has obviously been broken.
  - o After six hours of reconstitution of measles vaccine no matter the degree of sterility of procedures if the vial has not been used up during the session.



#### Administering the Measles Rubella Vaccine

The following steps should be followed:

1. Give 0.5mls of measles rubella vaccine injection through subcutaneous route on the upper left arm for a child aged 9 months to under 15 years.
2. Hold the child's arm from underneath. Your fingers should reach around the arm and pinch up the skin.
3. Push the needle into the pinched skin to a depth of not more than 1 cm. The needle should go in at a sloping angle, not straight down.
4. Press the plunger with your thumb to inject the vaccine.
5. Withdraw the needle and drop the syringe and needle in the safety box.
6. If there is any bleeding, press the bleeding site with a dry cotton wool. Don't rub.



#### Remember

- Use measles rubella vaccine diluent of the same manufacturer to reconstitute the vaccine.
- Never reuse mixing syringes to reconstitute subsequent vials
- Make sure the vaccination area is clean and all waste safely disposed off



#### Remember

- Wash your hands before start of the session
- Never pre-fill vaccine syringes.
- Do not give vaccine to any child who has had an anaphylactic reaction following the administration of ANY vaccine.

### The following are NOT contraindications to vaccination

- HIV infection.
- Malnutrition: Malnutrition is an indication to immunize. Malnourished children should be referred to clinician for assessment and treatment after they have been immunized.
- Minor illness: Low grade fever, mild respiratory infections, and diarrhoea. Sick children should be referred for treatment after they have been immunized.

## 7.2 Ensuring Safe Injections

The auto-disable syringe is the preferred type of disposable injection equipment for administering vaccines. This type of syringe is the preferred choice for conducting mass vaccination. The auto-disable syringes minimize the risk of person to person transmission of blood borne pathogens because it cannot be reused.

### Using auto-disable syringes and mixing syringes with Re-Use Prevention (RUP)

- 5.0 mls sterile mixing syringe with RUP will be used to mix diluents to only one vial of MR vaccine; after dilution put it straight into the safety box.
- A sterile packed 0.5 ml auto-disable syringe must be used for each injection for each child.
- Immediately after injecting the child place the syringe in the safety box. DO NOT leave the syringes lying on the table, in a tray or anywhere else after injection: put it straight into the safety box.
- DO NOT ATTEMPT TO RECAP THE NEEDLE. This practice can lead to needle stick injuries.
- Do not use auto-disable syringes from damaged or punctured sterile packs or which have passed the manufacturers' expiry date.



### Monitoring injection safety

Supervisors need to be trained in the monitoring of injection safety and to include relevant questions in their supervisory checklists during the implementation. The **Implementation Checklist** (see Annex 3) should be used as a tool for a rapid assessment on injection safety during IMRC.

## 7.3 Ensuring Safe Disposal of Injection Equipment

### Disposal of Used syringes and needles

All used syringes and needles must be disposed immediately after use throughout the IMRC by dropping them into the safety boxes provided in all vaccination posts. These boxes reduce the risk posed by contaminated needles and syringes to both the health staff and the general public. Vaccinators should place used needles and syringes in safety boxes immediately after dilution and administering vaccine. Close the nearly (approximately 3/4) full box securely shut and store the box in a safe place until it can be properly disposed of, so as to prevent infecting yourself, other health care workers and the community. To avoid an occupational hazard, safety boxes should not be over-filled. One box can hold 90 to 100 syringes and needles. Used syringes should not be transferred from container to container, and must not be left in a public area of the post or health facility. Do not transfer filled safety boxes from one place to the other if you expect any damage to the containers to allow spill or uncontrolled drop of used sharps.



#### Remember

- The safety boxes should be properly assembled according to instruction printed on the boxes.
- The open safety boxes with used syringes and needles are DANGEROUS

#### 7.4 Handling and disposal of Safety boxes

Used syringes and needles at immunization posts will be discarded in the safety boxes provided for the purpose. At the end of each implementation day, safety boxes will be disposed of as follows: for immunization posts located at a distance of less than 5 km from incinerators, the filled safety boxes should be collected for incineration and those more than 5 km from incinerators should be collected and burnt in a 1m deep pit at the vaccination posts. Supervisors will oversee the ultimate disposal by burn and bury by either the pit method

##### Pit Burning

- Choose an unused area for the burning site, as far from buildings as possible. The area should be cleared.
- Dig a pit at least 1.5 meter wide and 2 metres deep
- Place the filled safety boxes in the pit. Mix paper, leaves, or other flammable materials among the boxes to help them burn.
- Warn people to stay away and avoid smoke, fumes, and ash from the fire.
- Burn until all boxes are destroyed
- Use the pit on subsequent implementation days, covering completely each layer of burned waste with a thin layer of soil till the last day.

##### Posts in Urban areas

Explore availability of appropriate waste disposal such as incinerator in urban area or designate a suitable disposal location for a burn and bury pit. Supervisors will also oversee the ultimate disposal of sharps.

##### Disposal of Other Wastes

Any other waste should **NOT** be put into the safety boxes. Instead, other waste should be disposed of in a bin and burned regularly along with the safety boxes.

#### 7.5 Administering tOPV

tOPV is a live attenuated (weakened) polio virus vaccine. It comes either in a plastic form with its tip as the dropper or in a glass vial to which a separate plastic dropper will be attached. To administer tOPV the following should be followed:

- Check the expiry date and the stage of VVM (use only if in stage I or II). Hold the vial at an angle to the child's mouth.
- The child should be standing up right or the mother/care giver should hold the child sitting upright and firmly. This is to avoid aspiration of the vaccine.
- Ask the child to open his/her mouth or open the child's mouth by squeezing gently between your fingers (if an infant).
- Squeeze the dropper to express two drops of tOPV in to the child's mouth.
- Make sure the child swallows the tOPV.
- If the child spits out the vaccine, give another dose.



##### Remember

*Make sure the dropper does not touch the child's mouth*

#### 7.6 Administering Vitamin A

##### Steps of administering Vitamin A

The following steps should be followed in administering Vitamin A.

- As each child arrives, find out his/her age and decide the correct dose for the age group.
- Give:

- Infants 6-11 months: 100,000 IU
- Children 12-59 months: 200,000 IU
- Use scissors to cut the nipple of the vitamin A capsule and squeeze out the drops into the child's mouth.
- The child should be standing up right or the mother/care giver should hold the child sitting upright and firmly. This is to avoid aspiration of the Vitamin A drops.
- Discard all used vitamin A capsule in a plastic bag or container.
- Put one mark on the tally sheet for each child given vitamin A.



### Requirements for vitamin A supplementation

Each health facility or vaccination post needs the following;

- Vitamin A capsules ( 100,000 IU and 200,000 IU)
- Scissors or to cut the capsule;
- Plastic bag or container to dispose of used vitamin A capsule,
- Tally sheet and summary forms.

## 7.7 Administering Mebendazole

### Deworming drug

During the campaign children aged 1 to 5 years will be dewormed with Mebendazole. This has been a drug of choice as it is safe and used as a single dose compared to other de wormers. Also has an advantage of being same dose regardless of age. Mebendazole tablet is 500 mg and all children are given a single tablet. Tablets are chewable and normally fruit flavoured, which means it is not difficult to persuade children to take them. Can be crushed between two spoons and given with a glass of water for children that have difficulties in swallowing the tablets.

### Age recommended for de-worming children from the age of 1 year

It is safe and recommended in highly endemic areas to start deworming children from the age of 1 year. If a child younger than 1 year is treated by accident, or if a child is given several repeated doses (for example, if he or she has recently been treated at a health clinic and then receives another tablet during a mass campaign), no harm will be caused (for other parasitic diseases, higher doses of Mebendazole are given daily for between 30 days and 6 months without reported side-effects).

### Storage

Transporting and storage of Mebendazole is easy. No special precautions are necessary beyond storing them in a closed container and keeping them out of extreme heat and humidity. In terms of the space needed, a container of 200 tablets is about the same size as a soft-drink can, so, according to the estimated need, one or more such containers can easily be sent out with vitamin A supplements to each distribution site.



#### Remember

- *Mebendazole is safe; single dose and simple to administer*
- *All children above one year are given one tablet*

## CHAPTER 8: ADVOCACY, COMMUNICATION AND SOCIAL MOBILISATION

### 8.1 Introduction

The goal for advocacy, communication and social mobilization is to inform and educate the community, parents and other care givers in order to help them understand and improve demand for immunization services on a routine basis. It is also to help planners, managers and service providers understand and work better with the beliefs, structures and need of the community so that services are more responsive and effective. This can be done across cultures, political systems and all governance structures in the country. If implemented effectively, this guideline for advocacy, communication and social mobilization will empower communities and care givers to access accurate and timely information, resulting in greater public awareness, acceptance and guide appropriately public/community involvement and participation, to support the Integrated Measles Rubella Campaign (IMRC).

### 8.2 Organisation of Advocacy, social mobilisation committees

The planning and management of Social Mobilization activities is a key factor to success. In this respect, having a hierarchy of Advocacy and Social Mobilization committees through the various administrative levels has been found to be effective in securing leadership and community ownership in mass campaigns. As much as possible, committees should come from pre-existing government administrative structures. The committees should be multi-sectoral but with clearly defined roles and responsibilities.

All stake holders need to be involved from the beginning of the process while preparing for the integrated measles rubella campaign. The aim is to obtain support from policymakers and decision makers at different levels (National, Regional, Council and local) by participating in activities, providing financial support and persuading others to participate.

#### National level

At national level there is a Multisectoral Advocacy and Social mobilization committee.

<b>National Multisectoral Advocacy and Social mobilisation committee.</b>	
10.	Ministry of Gender, Women and Children
11.	Ministry of Health and Social Welfare
	<input type="checkbox"/> Immunization and Vaccine Development (IVD)
	<input type="checkbox"/> Reproductive Health Unit
	<input type="checkbox"/> Health Education Unit
12.	Faith Based Organization
13.	Media
14.	Red Cross
15.	Development Partners (WHO, UNICEF,USAID,CHAI , John Hopkins, Rotary Club, Red cross and others)
16.	Civil Society Organization (optional)
17.	Ministry of Education
18.	Lions Club

#### Roles and Functions

- To conduct national advocacy interventions with key stakeholders to ensure visibility and prioritization of immunization campaigns and to seek financial and political support
- To oversee the planning and implementation of advocacy, communication and social mobilization strategies and activities.
- To identify the resource needs
- To mobilize possible partnerships at all levels including CBOs, NGOs, FBOs etc

- To ensure effective interface and coordination between operation and social mobilization plans and Oversee the development, review, production and dissemination of IEC materials and messages for TV, Radio, Newspapers and posters and for interpersonal communication
- Monitoring of evaluation of advocacy , communication and social mobilization plans and activities including response to non-compliance due to rumours, refusals and other bottlenecks

### Regional level

At regional level there is a Regional Multisectoral Advocacy committee which comprises of

<b>Region Advocacy and social mobilisation committee.</b>	
1.	Regional Commissioner - Chairperson
2.	Regional Administrative Secretary
3.	Assistant RAS Social Sector
4.	Faith Based Organizations
5.	Community Development Officer
6.	Representatives of NGO (Involved in Immunization)
7.	Representative of Red Cross
8.	Regional Health Management Team
9.	Representative of Media Institutions in the Region
10.	Regional Nutrition Officer
11.	Regional School Health Coordinator
12.	Regional Education Officer

### Roles and Functions

- To conduct regional advocacy meeting for seeking financial and political support
- To oversee the planning and implementation of advocacy and social mobilization activities in the region.
- To coordinate social mobilization activities at regional level
- To supervise and support social mobilization efforts at Council level
- To disseminate advocacy and social mobilization materials in the region
- To prepare opening ceremony at the regional level
- Dissemination of messages for TV, Radio, Newspapers and posters
- Monitoring of advocacy and social mobilization activities in the region
- Identify and respond to non-compliance due to rumours, refusals and other bottlenecks

### Council level

Composition of Council Advocacy and Social mobilization committee

<b>Council Advocacy and social mobilisation committee.</b>	
1.	District Commissioner – Chairperson
2.	Mayor/Chairman of Council
3.	Council Executive Director
4.	Chairperson social services committee
5.	Council Medical Officer – Secretary
6.	Council Community Development Officer
7.	Council Education Officer
8.	Religious Leaders
9.	Representatives of NGO (Involved in Immunization)
10.	Representative of Red Cross
11.	CHMT
12.	District education officer

### Roles and functions

- To ensure that IMRC is an agenda of the full council meetings.
- To identify high risk wards, villages and settlements in the Councils
- To conduct Council advocacy meeting in for resource mobilization.
- To oversee the development of micro planning and implementation of advocacy and social mobilization activities in the Council.
- To coordinate social mobilization activities at Council level
- To supervise and support social mobilization efforts at ward level
- To prepare launching ceremony at the Council level
- Monitoring of advocacy and social mobilization activities in the Council
- Identify and respond immediately to rumours

### Ward level:

#### Ward Advocacy and social mobilisation committee.

1. Councillor – Chairperson
2. Ward Executive Officer
3. In charge of HC or dispensary – secretary
4. Ward Education Coordinator
5. Ward Community Development Officer
6. Village chairpersons
7. Village executive officers
8. Faith based Organisation
9. Representatives of NGO
10. Health Officer
11. Influential leaders
12. Village education officer/school headmasters representative

### Roles and functions

- To conduct advocacy meeting at ward level.
- To oversee the development of micro planning and implementation of advocacy and social mobilization activities in the ward.
- To coordinate social mobilization activities at ward level
- To supervise and support social mobilization efforts at village level
- To supervise distribution of advocacy and social mobilization materials in the ward.
- Monitoring of advocacy and social mobilization activities in the ward
- Identify and immediately respond/report rumours to Council level

### Village/Mtaa level

#### Village Advocacy and social mobilisation committee.

1. Village/Mtaa Chairman – Chairperson
2. Village/Mtaa Executive Officer
3. In charge of HC or dispensary – secretary
4. Head Teachers
5. Religious Leaders
6. Representatives of NGO
7. Village Health Worker
8. Influential leader (1)
9. Community mobilizer
10. School teachers representative

### Roles and functions

- To conduct advocacy and sensitization meetings at village/mtaa level.
- To oversee the development of micro planning and implementation of advocacy and social mobilization activities in the village/mtaa/HF/vaccination posts.
- To coordinate social mobilization activities in the village/mtaa
- To inform villagers/residents about the campaign, dates of planned activity and vaccination post
- To advocate support for vaccinators during the campaign.
- To supervise distribution and display of advocacy and social mobilization materials in the village/mtaa/health post/HF.
- Monitoring of advocacy and social mobilization activities in the village/mtaa
- Identify and report rumours to ward and Council level
- To visit houses before and during the campaign to check children eligible to receive interventions

### Community mobilizer

Each vaccination post will have a community mobilizer who will be selected by village leaders to work for one day before the campaign and seven days during the campaign. He/she must be a mature, respectable person and committed to do the work.



#### Remember

- *Mobilization is the key to success for campaign*
- *Council can increase the number of mobilizers and days according to their needs*

### Roles and functions:

- To inform villagers/residents about the campaign, dates of planned activity and vaccination post
- To inform parents/guardians and children about all interventions available
- To visit houses before and during the campaign to mobilize the community to turn up to the vaccination post to receive interventions
- In case of low turn up to follow children at home and mobilize parents/guardians to bring them to a vaccination centre
- To report progress to the village/mtaa social mobilization committee

### 8.3 Advocacy

Advocacy is the process of soliciting the support of individual and key organizations responsible for formulating policies, making decision and allocating resources. Advocacy for IMRC comprises of activities to gain and maintain the support of opinions and decision makers for programme, to raise resources and commitment. This includes political, resource and policy support.

### 8.4 Communication

Communication for IMRC campaign is a broad process that aims at informing, educating and engaging, the community. Using the mass media (Television, Radio and Newspapers) and interpersonal channels, key messages will be disseminated wide especially in areas with low immunization coverage, hard to reach, previous history of resistance or rumours.

Social Mobilization Technical Team will create specific radio spots, television programmes and news casts that will be aired and printed for 8 weeks prior the campaign up to the last day of the IMRC explain and inform the community on the following issues:

- Target groups;
- The reasons behind the campaign;
- Dates and duration of the campaign; and
- Health benefits of receiving campaign interventions.



### Remember

*All messages must be adapted from key messages prepared at the national level*

## 8.5 Community mobilization

Integrated Measles Rubella Campaign should reach all eligible children. Clear messages therefore need to be designed and disseminated through methods that are suitable for reaching such parents and others who can influence or motivate them. While these methods include the traditional media, experience has shown that interpersonal communication plays a major role in informing and convincing parents to bring out their children.

### Role of Community Leaders (including Traditional and Religious leaders)

- To inform their followers about the campaign, dates of planned activity and vaccination post
- To provide information on the benefit or importance of campaign interventions
- To allay anxiety to the community
- To participate actively during the campaign

### Role of Community Health Workers/Extension workers

- To inform the community about the campaign, dates and planned activity and vaccination
- To conduct house to house community mobilization
- To provide information on the benefit or importance of campaign interventions
- To allay anxiety to the community
- To trace and respond or report rumors or misconception of IMRC to higher authorities

### Role of School Authorities

School authorities will play a very important role in giving information to all schools within the areas of jurisdiction.

Specific roles will include

- To inform all school head teachers about the campaign, dates of planned activity and vaccination post
- To inform head teachers to prepare school as vaccination post
- To disseminate, distribute and display IEC materials for the campaign
- To provide information to students on the importance of the campaign interventions
- To inform parents about the campaign and consent for their children to receive interventions

## 8.6 Planning for Social Mobilisation

Social Mobilisation planning for the IMRC by the Region and Council social mobilization Committees should answer the following questions:

1. Which are the most high risk villages and settlements in the Councils?
2. In these villages/mitaa, which are hard-to-reach (in terms of their attitudes their social status, values, sects or physical remoteness)?
3. What challenges emerged during the last campaign?
4. Which of these challenges remain unresolved (e.g. inadequate knowledge of AEFI)?
5. What are the primary audiences that must be reached through household mobilization, peer and community dialogue? *These audiences should be prioritized for the immediate campaign according to importance for addressing challenges related to non-compliance, ensuring community support and gaining access to hard-to-reach areas or schools*
6. What traditional leader(s), Religious leaders, Community Health Workers, Community-based organization (s), or opinion leaders must be engaged if the unresolved challenges are to be resolved?
7. What challenges must be tabled for discussion and messages shared during the upcoming dialogue sessions?

8. What other activities (e.g. orientation of community mobilizers, messaging by town announcers, mass media interactive sessions, or home visits by key community-based groups) should take place to enable us mobilize all segments of the community, Council and Region?
9. What will our work plan cost (financial and human resources)?
10. What resources are available locally to ensure achievement of our objectives?

### **8.7 Frequently asked questions**

Frequently asked questions are attached as Annex 3 and 4. They need to be referred in case any questions are asked.

### **8.8 Anticipating and dealing with negative publicity and rumours**

Experience has shown that we must anticipate some negative publicity during campaigns and develop pro-active strategies of dealing with them so that they will not play a prominent role in hampering campaign activities. Some tips of dealing with these rumors and negative publicity include:

- Providing training and accurate information to the media
- Preparing appropriate media materials in advance to facilitate a rapid response to such negative claims
- Inform the Regional and Council advocacy and social mobilization committees to be prepared to respond to questions
- To provide guidelines to health personnel on how to respond to rumors and negative publicity. Guidance on this must be given to them especially on dealing with media and the public
- Using Regional and Council Commissioners as spokespersons in their areas of jurisdiction quell the rumors and negative publicity and reassure the community

### **8.9 Advocacy, Communication and Social Mobilization for MR routine immunization.**

After MR Campaign, MR vaccine will be incorporated immediately in RI and measles vaccine will no longer be in use. Therefore any ACSM activities will be dealt with according to National Immunization communication strategy .The operationalization of the ACSM activities will be coordinated routinely at National, Regional, District, ward, village and Health facility levels through National ACSM sub technical working group, routine PHC committees at regional and district levels as well as Ward Development Committee (WDC) and Health Facility Committee at ward and health facility levels respectively.

Routine MR Implementation as part of other routine vaccines implementations should utilize the potential of Village Health Workers and other community owned Resource Persons-CORPs in linking services with community through;

- Defaulter tracing
- Reporting home births
- RI community sensitization and mobilization
- Liaising with HWs in organizing and conducting outreaches services
- Tracing and following up of children whose vaccination dates are due at their homes and convincing their parents/caretakers to take them at health facility for vaccination.
- Reporting to HF in charge and village leaders on non-compliers.

## CHAPTER 9: ADVERSE EVENTS FOLLOWING IMMUNIZATION

### 9.1 Adverse Events Following Immunization

An adverse event following immunization (AEFI) is any untoward medical occurrence which follows immunization and which does not necessarily have a causal relationship with the usage of the vaccine. Although people often think that a medical incident after an immunization must be caused by the immunization, many such incidents are coincidental. Another belief – that vaccine is the most common cause of AEFI – is also mistaken. Although modern vaccines are safe, no vaccine is entirely without risks. The goal of immunization is to protect the individual and the public from vaccine-preventable diseases.

Most vaccine-induced reactions are mild and temporary. “*Serious AEFI*” are extremely rare and are defined as those events that result in death or hospitalization. A “*mild AEFI*” is defined simply as one that is not serious. Serious AEFI occur at rates that are in small fraction of the rate of complications caused by the disease itself.

Adverse reactions following immunization can undermine an immunization programme by causing parents and the community to lose confidence in the benefits of immunization. Therefore, it is important that immunization programmes monitor serious adverse events following immunization and that appropriate action is taken to correct any programmatic errors. The handling of AEFI should be included as part of the required training (pre-assessment questionnaire, definition and identification of the specific AEFI, reporting of AEFI and reassurance of the public) for the implementation of the mass campaigns.

### 9.2 Identifying adverse events

Four “trigger events” which must be monitored during the routine and supplementary immunization are as follows:

- Any injection site abscess following immunization
- Any case requiring hospitalization that is thought by health workers or the public to be related to immunization
- Any other severe or unusual medical incidents believed by health workers or the public to have been caused by, or related to, immunization
- Any death believed by health workers or the public to be related to immunization

### 9.3 AEFI Category

AEFIs are divided in categories

#### **Vaccine product related reaction**

An AEFI is caused by a vaccine due to one or more of the inherent properties of the vaccine product. Example: Extensive limb swelling following DTP vaccination.

#### **Vaccine quality defect related reaction**

An AEFI that is caused or precipitated by a vaccine that is due to one or more quality defects of the vaccine product including its administration device as provided by the manufacturer.

Example: Failure by the manufacturer to completely inactivate a lot of inactivated polio vaccine leads to cases of paralytic polio.

#### **Immunization error related reaction**

An AEFI is caused by inappropriate vaccine handling, prescribing or administration and thus by its nature is preventable.

Example: Transmission of infection by contaminated multidose vial.

#### **Immunization anxiety related reaction**

An AEFI arising from anxiety about the immunization

Example: Vasovagal syncope in an adolescent during/following vaccination.

### Coincidental event

An AEFI is caused by something other than the vaccine product, immunization error or immunization anxiety.

Example: A fever occurs at the time of the vaccination (temporal association) but is in fact caused by malaria. Coincidental events reflect the natural occurrence of health problems in the community with common problems being frequently reported.

### 9.4 Incidence of AEFI

Under recommended conditions, all vaccines approved for use in immunization are safe and effective if used correctly. The key therefore is to minimize as much as possible adverse events and ensure a safe use of vaccines. Adverse events following immunization (AEFIs) are classified by the cause of the event. During mass vaccination campaign it is expected to cover more children using MR vaccine and enhance the probability of adverse events is higher and more noticeable.

### 9.5 Handling AEFI during the campaign

AEFI will be monitored up to 4 days after administration of the vaccine. Identified focal persons, training, logistics requirements, and communication are key issues to be addressed in handling AEFI during the campaign.

#### Focal persons and Training in handling of AEFI

During the planning and training sessions for the campaign, the focal persons for handling AEFI in each Council and at each health facility should be designated. These are the persons who should be alerted immediately when an AEFI is reported, and who should assist in the handling and investigation of the case. All health workers who are involved in the campaign and who see sick children at health facilities and vaccination post should know who the focal persons are. These people need to be with clinical background. All health workers who are involved in the immunization will be trained in the detection and handling of AEFI, which should include procedures for dealing with the public.

#### Logistics requirements

Each fixed post should have easy access to a facility where an emergency kit is positioned or have an emergency kit at each post and an AEFI focal person on standby. The team at the post must all be aware of the location of the nearest kit and must make a contingency plan to alert the facility or to fetch the kit – **every minute counts!**

The emergency kit should consist of adrenalin (1:1000), hydrocortisone, analgesics, anti-inflammatory agents, normal saline, and injection equipment (2 mls and 10 mls syringes and needles and intravenous giving set). Every fixed post must have a supply of AEFI case investigation forms.



#### Remember

*The AEFI Focal Person at the health Facility level is the Clinician In-charge; at Council level is the DMO or clinician designated for AEFI and at the Regional Level is the RMO or clinician designated for the same purpose*

### 9.6 Treatment of AEFI during the campaign

Treatment must always be the first response to an AEFI. All severe AEFI cases should be referred immediately to the nearest health facility or hospital for treatment. The case investigation form must be quickly filled in as far as possible and accompany the patient being referred, otherwise the investigation may not be followed up. Case investigation forms should be filled for every case of a severe AEFI.

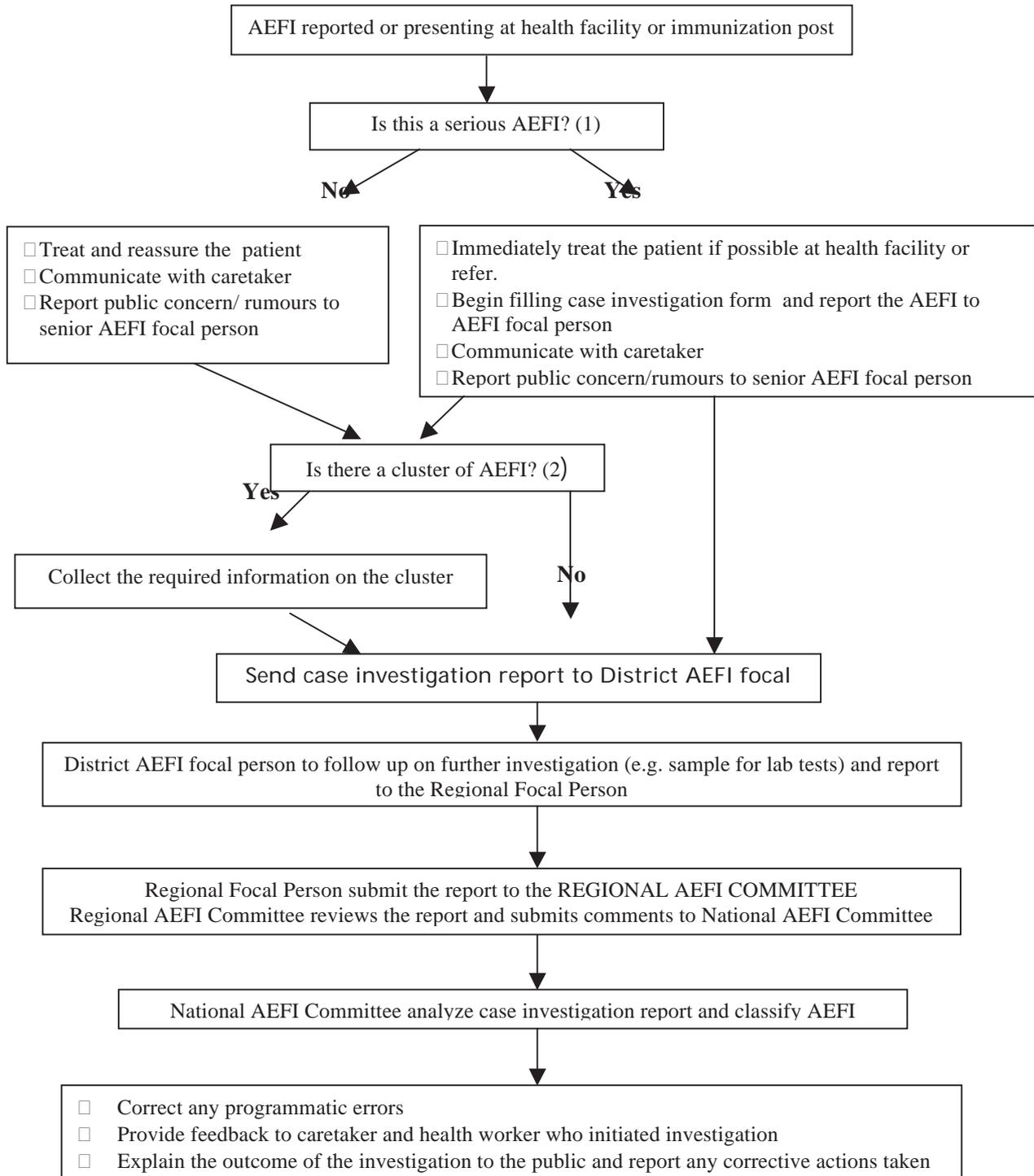
- Cases of anaphylaxis should be treated at the health facility where the immunization took place or at the facility with an emergency kit that is closest to the fixed post.
- Mild symptoms such as fever can be treated at home or by health workers. Health workers must be able to decide which AEFI to treat and which to refer...
- Treatment for AEFI should be free of charge.



### Remember

- Any anaphylaxis require immediate attention)
- Do not PANIC! Reassure the client

### ACTIONS TO BE TAKEN IN THE CASE OF AEFI



### Notes

1. Defined as **Serious** if it results in hospitalization or death.
2. A Cluster is defined as AEFI that occur with unusual frequency, by vaccine, by batch number, by type of reaction, or by health facility/ community.

### EMERGENCY PROCEDURE IN THE CASE OF ANAPHYLAXIS

Anaphylaxis is a very severe reaction, which may occur rarely after any injection including a vaccination. The patient collapses with signs of shock and breathing problems. If this occurs, follow the steps described below immediately.

1. Call for help and attend to patient immediately.
2. Check breathing and heartbeat.
3. If the patient is not breathing:
  - Secure the airway and ventilate
  - If there is no heartbeat:
  - Do CPR (cardio-pulmonary resuscitation)
4. Give adrenalin 1:1000
  - Children under 3 years: 0.1 ml subcutaneous at once
  - Children 3-5 years: 0.2 ml subcutaneous at once
  - Children 6- 12 years 0.3 ml subcutaneous at once
  - Children above 12 years 0.5 ml subcutaneous at once/ Intramuscular
5. Give adrenalin as follows: 1 ampoule diluted with normal saline to 10 ml in small amounts slowly IV. The heart rate should not exceed 160/minute.
6. Give hydrocortisone sodium succinate slowly IV or IM in the following doses:

Children 6 months- 6 years:	50 mg
Children 7- 12 years:	100 mg
Children above 12 years	200 mg
7. Set IV drip and run the Normal saline drip fast



#### Key point

The difference between a reaction related to the vaccine and an adverse event which can have other causes should be explained to patients and parents. This ensures that they have all information they need to make an informed decision about receiving an immunization for themselves or their children.

Trusted and well-informed health care providers are best suited to provide such information. Information about the immunization(s) should be provided well ahead of the immunization visit. This gives parents the time to understand the information well and ask questions that will increase their trust.

#### 9.7 Recommendations to Minimize AEFI

- Measles Rubella vaccine must be reconstituted only with the diluent supplied by the manufacturer.
- Always check the validity of the vaccine, diluents, syringes and needles by observing Expiry date, batch number and VVM Status
- Reconstituted vaccines must be discarded at the end of each immunization session or after six hours of reconstitution and NEVER retained for use in subsequent sessions.
- In the refrigerator of the immunization centre, no other drugs and substances should be stored beside vaccines.
- Training of immunization workers and their close supervision to ensure that proper procedures are being followed are essential to prevent deaths or injury following immunization.
- Careful epidemiological investigation must be carried out in the event of adverse events following immunization. Complete investigation of AEFI is of critical importance to pinpoint the cause of the incident and to correct immunization practices so that future AEFI is prevented.

## CHAPTER 10: REACHING THE UN-REACHED CHILDREN

### 10.1 Background

One of the important elements of a high quality integrated Measles Rubella campaign is reaching the un-reached areas of the Councils, and the underserved populations who are often missed by routine immunizations. The most important questions which need to be answered are ‘**who**’ and ‘**where**’ are the un-reached in the Council? These will lead to the next question of ‘**why**’ these populations are un-reached, and thus help Council Technical team to develop effective strategies on ‘**how**’ to reach them. These groups include those:

- Populations known to have a high disease burden.
- Known areas of un-immunized or under immunized children
- Populations with poor sanitation
- Populations living difficult or mountainous terrain
- Refugees, internally displaced persons, migrant workers and other transient populations.
- Socially marginalized populations or minority groups
- Religious groups who oppose vaccination

### 10.2 Strategies

Reaching the un-reached populations often requires working through local "non-official" leaders or informal channels through religious leaders and NGOs. Such agents as are accepted by them should be approached to participate in the development and implementation of appropriate strategies aimed at reaching them.

*Measles Rubella campaigns require at least 95 % coverage to be effective therefore seek out all eligible children during campaigns  
Reaching the un-reached is more difficult. Therefore, extra effort and time is required with more human and financial resources.*

Strategies to reach the un-reached population include:

- Develop detailed micro plan in order to carefully plan the extra logistics and social mobilization needed to reach these populations.
- Involve community and religious leaders of the underserved population in the planning, social mobilization including special efforts to dispel false rumours.
- Understand and overcome barriers (cultural, educational, logistical, language or religion) that keep un-reached populations from bringing their children for immunization.
- Using temporary posts during campaign
- Place extra posts in strategic highly visible, and/or highly convenient sites such as markets, bus stand, and major waterways to reach transient populations.
- Provide additional logistical support such as vehicles and mobile teams in areas with un-reached populations.

### 10.3 Spot check of un-reached areas before the campaign.

Three days before campaign, the Council Supervisor, community leader and social mobilizer should go to the most under-served, high density urban areas to verify that mothers know about campaign. This will give enough time to correct the situation by last minute intensified social mobilization. Before and during campaign, the supervisors should actively and frequently supervise preparations and efforts to reach un-reached populations.



#### **Remember**

*Allocate the most active and enthusiastic supervisors to supervise preparations and efforts to reach un-reached populations in the most difficult to reach areas*

#### **10.4 Follow-up in areas that were missed**

Reaching the “hard-to-reach and the underserved populations will require additional time, logistics, personnel and social mobilization activities. In case Rapid Convenience Survey indicates that, certain groups could not be reached during the campaign despite all preparations and efforts to do so, then additional efforts should be made to reach them before the end of the campaign, or “mop-up campaigns specifically targeting these areas should be organized within a short time.

## CHAPTER 11: DATA MANAGEMENT

### 11.1 Vaccination team tally sheets

#### Measles Rubella vaccination daily implementation tally sheet

Separate tally sheet will be provided for measles rubella vaccine. On top of each tally sheet there is a part showing the name of the council and health facility, amount of the measles rubella vaccines supplied to the vaccination team, used, returned and reminder for teams to check the Vaccine Vial Monitor status.

Each settlement visited by the mobile-temporary must be indicated and show children vaccinated per settlement. Below the tally sheet there is row showing the total of children immunized at that vaccination post. Teams at fixed posts will use the same tally sheet and there is no need to indicate the name of settlement. In case more children than 112 are vaccinated the next row can continue to be used. These tally sheets will be submitted to the Health facility in-charge at end of the day of implementation. *(See Annex 8a for MR tally sheet)*

Behind the measles rubella tally sheet there is AEFI case register. All AEFI cases either minor or serious need to be recorded and outcome indicated. *(See Annex 8b for AEFI tally sheet)*

#### tOPV Daily Implementation tally sheet

Separate tally sheet will be provided for tOPV. On top of each tally sheet there is a part showing the name of the council and health facility, amount of the tOPV vials supplied to the vaccination team, used, returned and reminder for teams to check the Vaccine Vial Monitor situation.

Each settlement visited by the mobile-temporary must be indicated and show children vaccinated per settlement. Below the tally sheet there is row showing the total of children immunized at that vaccination post. Teams at fixed posts will use the same tally sheet and there is no need to indicate the name of settlement. In case more children than 112 are vaccinated the next row can continue to be used. These tally sheets will be submitted to the Council Supervisor at end of the day of implementation. *(See Annex 8b for tOPV tally sheet)*

Behind the measles rubella tally sheet there is AFP cases detected register. Caretakers must be asked of AEFI cases in the community. *(See Annex 8ab for AEFI tally sheet)*

Separate tally sheet will be provided for Vitamin A and Mebendazole. On top of each tally sheet there is a part showing the name of the council and health facility, amount of the Vitamin A and Mebendazole supplied to the vaccination team, used, returned and reminder for teams to check the Vitamin A/Mebendazole situation. *(See Annex 8c and 8d for Vitamin A and Mebendazole tally sheet respectively)*

### 11.2 Health Facility daily summary sheets

The Council Supervisors will collect the Vaccination teams tally sheets, collate data and prepare two Daily Health Facility Summary Sheets. The summary sheet shows daily implementation status of each vaccination team. The summary comprise of

- total children given the intervention in each post
- total vaccines used and other devices

On the top part of the summary sheet the Council Teams Supervisor will write his/her name. Data will be entered per each vaccination team daily performance. This will help to monitor each team performance against the target given. In case the supervisors is supervising more than one health facility service area then he/she will enter the data starting all vaccination teams in first health facility and follow the vaccinations teams in the second health facility. This will help to monitor the performance per health facility. Below row the total will be indicated. Daily implementation data must be transferred or transmitted to the Council Coordinator using the available means of communication. *(See Annex 8e for health facility summary sheet)*



**Remember**

*Call in data is IMPORTANT to monitor the performance of all teams. Data must be transmitted using all available communication means to the councils.*

### 11.3 Council Summary sheet

The District Medical Officer will collect all Health Facility Summary, collate data and prepare Daily Council Summary Sheets. The summary sheet will comprise of

- total children given the intervention in each team
- total vaccines used and other devices

The Council Summary sheet it is advisable to be computerised for easy and quick analysis. The District Medical Officer must appoint a person to be entering the data in Excel spread sheet once they are sent from the Council Teams Supervisors. *(See Annex 8f for council summary sheet)*

District Medical Officer must make sure that the daily summary sheet is submitted at Regional level daily. This will help to monitor the council performance and immediately take action if needed.



**Remember**

*Daily Council data is IMPORTANT to monitor the performance of all teams. Data must be transmitted to region using email or available communication means.*

At end of the implementation Council Medical Officer will collate the Daily Council Summary sheets data in one Council Summary Sheet and submit officially to Regional Medical Officer.

### 11.4 Region Summary sheets

The Region Medical Officer after receiving the daily council summary sheet from the District Medical Officers will collate the data to the Daily Regional Summary sheet and send by email to Designated Officer at IVD Unit Ministry Health Social Welfare to give the daily status of implementation. *(See Annex 8g for regional summary sheet)*

At end of the implementation Region Medical Officer will collate the Council Summary sheets data in one Regional Summary Sheet and submit officially to Permanent Secretary Ministry of Health and Social Welfare.

## CHAPTER 12: SUPERVISION, MONITORING AND EVALUATION

### 12.1 Supervision, Monitoring and Evaluation

Definition of supervision, monitoring and evaluation

**Supervision** is a process that could assist health workers improve their performance through evaluation by peers, self-evaluation and team work

**Monitoring** is the process of continuous observation and collection of data on the immunization programme to ensure that the programme is progressing as planned.

**Evaluation** is a systematic and critical analysis of the adequacy, efficiency and effectiveness of the immunization programme; it is strategies as well as progress

Supervision is necessary to ensure quality of planning and implementation. The success of a campaign will largely depend on the work of motivated and hardworking supervisors who assist in the campaign preparations, support training and who identify and solve problems or refer issues to the next management level. Supervisors should be equipped with transport in order to bring extra and essential supplies with them during visits, such as forms, social promotion materials, guides, (vaccine when appropriate) and any needed funds for activities. The supervisors should be thorough and systematic when performing quality control checks and to ensure that:

- Pre-campaign phase: plans are adequate and estimations are correct
- During implementation: good quality vaccines and other interventions are safely given

Post-campaign: all children in the target group have been reached and wastes have been safely disposed off. National level will be responsible to oversee process of preparations in various regions and Councils with a focus to those with poor unsatisfactory micro plans

### 12.2 Pre implementation - Supervision and Monitoring

National level monitoring will be done regularly using the dashboard developed against timeline and responsible officers at different levels. Each region will monitor key preparation timeline and report to the national level with evidence the proportion of districts that are ready as per the timeline. The national level will provide report on status of preparedness using the SIAs readiness assessment tool to inform ICC and stakeholders on regular basis as per agreed timeline. The results will be used to guide implementation.

Supervisors from the National level should visit all Regions two weeks before campaign; however special visit can be done in the selected regions those with particular difficulties or questionable preparations.

Supervisors from the Region level supported by those from the National level should visit all Councils one week before campaign however special visit can be done in the selected Councils those with particular difficulties or questionable preparations.

If the Regions or Councils are found not to be well prepared after the supervisory verification visits emphasis should be to assist these Councils and regions to finalize preparations and implement the campaign.

Council and Local Supervisors should visit all the vaccination posts(including schools) and hard to reach areas before the campaign implementation

During each supervisory visit, the supervisor should complete the *Checklist for Verification of Preparations* (Annex I).



**Remember: Supervisors – making a difference**

*During the campaign, supervisors from all levels should actively visit posts to monitor, assist and help solve problems or take up issues to the next management level.*

**Qualities of an effective supervisor**

- Must be familiar with the area being supervised
- Is systematic, thorough, and a reliable problem solver
- Motivates and encourages local staff.
  
- Understands and is involved in the planning of the campaign
- Is fully knowledgeable of the tasks, logistics, and all other campaign forms
- Has experience in training others.

**12.3 Pre-Campaign Spot Check**

A campaign to be successful need the community to be fully informed on the interventions to be given, target age group and location and time they will be served. It is often useful to conduct a simple pre-campaign “spot checks”. National, region and Councils supervisors should make a spot check by visiting 5 -7 households in 3 randomly selected villages particularly in hard to reach areas or populations and their respective schools. This should be done 2-5 days before the campaign. Care takers /parents/school teachers will be asked to verify if they know about the campaign, the dates, the target age group and the location of the nearest vaccination post. If the survey indicates that social mobilization efforts are inadequate or ineffective, these must be intensified or messages changed immediately.

**12.4 Implementation - Supervision and Monitoring**

During implementation the supervisor should complete the *Implementation Checklist* (Annex II)

High risk, hard-to-reach, densely populated areas and schools should receive more intense supervision with the best supervisors.

**12.4.1 Administrative coverage**

At the end of each day, supervisors should assess the accomplishments by reviewing the tally sheets of the teams under their supervision, comparing the number of children vaccinated against the micro-planning and community line listing targets established for the various teams.

Any campaign result less than 85% coverage requires that the supervisors determine the reasons for the poor performance. Using the supervision checklists, Region/Council Team should review and discuss the logistical, social mobilization and operational problems that may have impeded the vaccination efforts. The successes should be documented and any lessons applied towards future campaigns. If there are pockets of unvaccinated children, a team of vaccinators accompanied by supervisors should in due time organise to return to the pockets and vaccinate them. The daily sharing of administrative results to next higher level from each level will be used to assess and monitor overall performance during the dates of the campaign. The sharing of information will be using text messages, telephone calls or e mail where applicable

**12.4.2 Rapid convenience survey - in process**

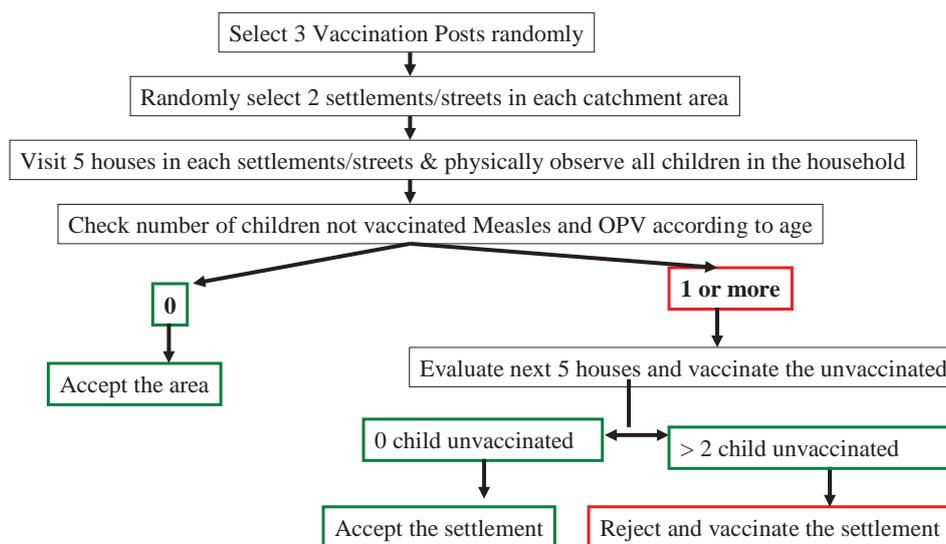
Unfortunately, vaccination coverage often relies on census or registration data that may not accurately reflect a target population. Coupled with migration and other factors, the resulting denominators may skew coverage estimates.

Rapid convenience surveys are excellent programmatic tools for local managers to identify poorly performing areas for immediate remedial action. They also are useful evaluation tools to assess the success of the campaign strategies in reaching the hardest-to-reach children. It's a logical way to identify pockets of unvaccinated children for quick action, and to help evaluate the effectiveness of social mobilization.

Monitoring of vaccination coverage should be done at various levels during the campaign and after the campaign to give some indication of on-going progress in reaching target-age children. The results for the rapid convenience survey done by supervisors and monitors will assist in taking action before the end of the vaccination campaign. Mop up vaccination will be done using the results from the rapid convenience survey if performance is below the target as per the flow diagram in the area.

### Steps for conducting rapid convenience surveys – in process

- National, regional and Council supervisors will conduct these surveys – in process.
- Select high-risk areas or populations to survey, using such criteria as:
  - Areas with history of un-immunized or under-immunized children;
  - Populations inhabiting difficult areas, hard to reach or mountainous terrain;
  - Refugees, internally displaced persons, migrant workers and other transient populations;
  - Homeless or street children;
  - Religious groups who opposed vaccination.
- Select three vaccination posts randomly daily in different Health Facility Service areas
- In each vaccination post service area randomly select 2 settlements or streets
- In each selected settlement or street randomly visit 5 houses
- In each household ask for all children under 5 years, physically see them and observe the left little finger mark
- If all children are left little finger marked record on the survey form in the respective column and accept the area
- If you find one or more children not left little finger marked in the household fill the information in the survey form and visit another 5 households and repeat the same process
- In the 5 households you find all children are left little finger marked fill the survey form and accept the area
- In case you find more children who are not left little finger marked in these additional 5 households reject the area, take a quick action to understand the reason and plan for appropriate action



**Note:**  
 Give priority to hard to reach and underserved areas  
 Involve community leaders in the monitoring process

### **12.5 Campaign Evaluation**

This should involve qualitative/process findings based on the results of the supervisors' reports and analysis of checklists as well as quantitative coverage results. Immunizations given during supplemental activities must be tallied, compiled, analysed and reported.

### **12.6 Post campaign community surveys:**

A post campaign community survey will be conducted after the measles rubella campaign by independent field survey teams. WHO coverage survey will be used to validate the campaign coverage that will be integrated with Routine Immunization coverage survey. The survey will be conducted within 4 weeks of the campaign and will use marked fingers for the campaign while cards will be used to assess routine immunization performance. A separate plan will be developed to detail out the post SIAs coverage survey plan.

### **12.7 Post Campaign Review Meetings**

At the end of the campaign, the committee members, supervisors, observers and coordinators at each level should conduct post campaign review meetings, and prepare a summary report of the results based on their checklists as well as their own impressions and experiences. These results should be used to evaluate the preparations and implementation of the campaign. The lessons learned should be documented and used to improve subsequent campaigns.

ANNEXES

Annex 1a: Target population by Council

1.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: TARGET POPULATION			
Region:			
Name of Regional Medical Officer			
No.	Council	NBS Target Population	Target population by Regional Administration
1			
2			
3			
4			
5			
6			
7			
8			
9			
	<b>Total</b>		
Signature of Regional Medical Officer: _____			

**Annex 1b: Health Facilities and Villages by Council**

2.0 REGIONAL INTEGRATED MEASLES CAMPAIGN MICRO PLAN: HEALTH FACILITIES AND VILLAGES									
Region:									
Name of Regional Medical Officer		Date:							
No.	Council	Number of Health Facilities	Number of Villages	Number of hard to reach communities	Measles-Rubella target population 9m-14 yrs	IOP target population 0-59m	Vitamin A Suppl Target Population	Deworming target population 12m-59m	
1									
2									
3									
4									
5									
6									
Total									
Signature of Regional Medical Officer: _____									

**Annex 1c: Personnel by Council**

**3.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: PERSONNEL**

Region:		Date:		Personnel											
Name of Regional Medical Officer		Date:		Personnel											
No.	Council	Measles target population 9m-14yr	iOPV target population 0-59m	Vitamin A Suppl Target Population 6m-59m	Deworming target population 12m-59m	Teams based on population: children per team	Council Coordinating Team (3)	Council Team Supervisors per 15 teams	2 Vaccinators per team		2 Recorder per team	Community Leader	Drivers	Independent Monitors	
									Required	Available					
1															
2															
3															
4															
5															
6															
<b>Total</b>							3								4

Signature of Regional Medical Officer: \_\_\_\_\_

**Annex 1d: Bundled Vaccines**

**4.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: BUNDLED VACCINES**

4.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: BUNDLED VACCINES											
Region:											
Name of Regional Medical Officer				Date:							
No.	Council	Measles target population 9-59m	bOPV target population 0-59m	Vitamin A Suppl Target Population 6m-59m	Deworming target population 12m-59m	Number of Teams	Vaccines and supplies				
							MR vaccines vials	MR diluents	AD Syringes	Safety boxes	tOPV doses
1											
2											
3											
4											
5											
6											
<b>Total</b>											
Signature of Regional Medical Officer: _____											

**Annex 1e: Data Management Tools**

5.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: DATA MANAGEMENT TOOLS																	
Region:																	
Name of Regional Medical Officer		Date:															
No.	Council	Number of Teams	Other materials														
			SAs Markers pens	Writing pens	MR tally sheets	tOPV tally sheet	vitamin A tally sheet	mebendazole tally sheet	Health Facility summary sheets	AEFI Forms	Council Summary Sheets	Pre implementation supervision checklist	Implementation supervision	Monitoring forms			
1																	
2																	
3																	
4																	
5																	
6																	
<b>Total</b>												10					
Signature of Regional Medical Officer: _____																	

**Annex 1f: Cold Chain and Logistics**

<b>6.0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: COLD CHAIN MANAGEMENT</b>										
Region:										
Name of Regional Medical Officer									Date:	
No.	Health Facility	Number of Council Supervisors	Number of Teams	Cold chain management						
				Vaccine Carriers	Ice packs	Cold boxes	Available Vaccines storage space DVS (L)	Available Vaccines storage space HF (L)	Available Ice pack storage space DVS	Available Ice pack storage space HF
1										
2										
3										
4										
5										
6										
<b>Total</b>										
Signature of Regional Medical Officer: _____										

**Annex 1g: Waste Management**

<b>0 REGIONAL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: WASTE MANAGEMENT</b>			
Region:		Date:	
Name of Regional Medical Officer		Waste management	
No.	Council	Functioning Incinerator	Using burn and bury method
1			
2			
3			
4			
5			
6			
<b>Total</b>			

Signature of Regional Medical Officer: \_\_\_\_\_



**Annex 2a: Council Health Facilities and Villages**

1.0 COUNCIL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: HEALTH FACILITIES AND VILLAGES									
Region:		Council:							
Name of District Medical Officer		Date:							
No.	Health Facility	Name of village	Number of settlements	Number of hard to reach communities	Name of village leader	measles target population 9m-14yrs	tOPV target population 0-59m	vitamin a target population 6m-59m	measles target population 12m-50m
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
		<b>Total</b>							

Signature of District Medical Officer: \_\_\_\_\_

**Annex 2b: Council Personnel**

2.0 COUNCIL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: PERSONNEL															
Region:															
Name of District Medical Officer												Council:			
No.	Health Facility	Measles Rubella target population 9m-14yrs	tOPV target population 0-59m	vitamin a target population 6m-59m	mebendazole target population 12m-59m	Teams based on population: children per team	Council Coordinating Team (3)	Council Team Supervisors per 15 teams	Vaccinator to give injection		Vaccinator to give OPV	2 Recorder per team	Community Leader	Drivers	
									Required	Available					
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															
18															
19															
20															
21															
<b>Total</b>							<b>3</b>								

Signature of District Medical Officer: \_\_\_\_\_



Annex 2d: Council data management tools

4.0 COUNCIL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: DATA MANAGEMENT TOOLS													
Region:		Council:											
Name of District Medical Officer		Date:											
No.	Health Facility	Number of Teams	Other materials									Monitoring forms	
			SIAS Markers pens	Writing pens	MR tally sheets	TOPV tally sheet	vitamin A tally sheet	mebenda zole tally sheet	Health Facility summary sheets	AEFI Forms	Pre implementation supervision checklist		Implementation supervision checklist
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21													
<b>Total</b>													
Signature of District Medical Officer: _____													

**Annex 2e: Council cold chain and logistics management**

5.0 COUNCIL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: COLD CHAIN MANAGEMENT										
Region:		Council:								
Name of District Medical Officer		Date:								
No.	Health Facility	Number of Council Supervisors	Number of Teams	Cold chain management						Available Ice pack storage space HF
				Vaccine Carriers	Ice packs	Cold boxes	Available Vaccines storage space DVS (L)	Available Vaccines storage space HF (L)	Available Ice pack storage space DVS	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
<b>Total</b>										
Signature of District Medical Officer: _____										

**Annex 2F: Council Waste Management**

**5.0 COUNCIL INTEGRATED MEASLES RUBELLA CAMPAIGN MICRO PLAN: WASTE MANAGEMENT**

Region:		Council:	
Name of District Medical Officer		Date:	
No.	Health Facility	Waste management	
		Functioning Incinerator	Using burn and bury method
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
<b>Total</b>			

Signature of District Medical Officer: \_\_\_\_\_



### Annex 3: Pre-implementation checklist for Fixed Post

#### TANZANIA INTEGRATED MEASLES RUBELLA CAMPAIGN (IMRC)

#### INSTRUCTIONS:

The checklist verifies the Region of preparedness for the IMRC at each of the following levels: Council and Health Facility Levels. Council verification must be done three weeks prior to implementation and the verification report must be submitted 2 days to implementation. Checklists should be completed and shared at Council level. Checklist should be scored by section (Yes = 1). Region of preparedness would be considered on course **if** scoring:

- 7-10 points in Section A: Planning,
- 4-6 points in Section B: Social Mobilization
- 3-4 points in Section C: Logistics.

For any section falling below these scores, document weak areas and plan for improvement before another pre-implementation review.

**Indicate Level of supervision:** (Council/Health Facility) circle one

Region \_\_\_\_\_ Council \_\_\_\_\_ HF \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

SUBJECT	YES	NO
<b>A. PLANNING AND COORDINATION</b>		
<b>1. Has a micro-plan been developed at this level?</b> <i>(Tick "YES" if you observe a copy of the micro-plan and the plan clearly addresses the target populations, vaccine requirements, personnel, transport, cold chain, injection safety and waste management plan )</i>		
<b>2. Has a detailed health facility catchment map showing the vaccination posts been developed at this level?</b> <i>(Tick "YES" if you observe a copy of the detailed health facility catchment map showing all vaccination posts, service areas, all settlements and schools )</i>		
<b>3. Has a detailed vaccination post daily implementation plan been developed at this level?</b> <i>(Tick "YES" if you observe a copy of the detailed vaccination post daily implementation plan)</i>		
<b>4. Is this level up to date in the implementation of planned activities?</b> <i>(Review the micro-plan with the Focal Person at this level to see if planned activities have been or are being implemented as planned. Tick "YES" if you are convinced that activities are being implemented as scheduled)</i>		
<b>5. Have adequate arrangements been made for covering hard to reach areas and special populations or groups such as nomads?</b> <i>(Each level is expected to identify hard to reach areas and special populations and plan specially for them. Tick "YES" if you are satisfied that this level has identified hard to reach areas and populations and that plans are in place to ensure that they are adequately covered during the campaign)</i>		
<b>6. Is there an effective inter-sectoral coordination mechanism at this level?</b> <i>(Each level is expected to hold regular inter-sectoral meetings (must include Education and Community Development) to coordinate planning and implementation of the campaign. Tick "YES" if you observe a copy of the minutes of such meeting held not later than 1 month ago)</i>		
<b>7. Have all required funds been made available to this level?</b> <i>(Tick "YES" if after a review of the micro-plan budget, the Focal Person at this level confirms that all required funds have been received.)</i>		
<b>8. Has this level secured all the personnel needed for the IMRC? And is the list available?</b> <i>(Tick "YES" if you observe the list of all identified – Local supervisor, 2 Health Workers as Vaccinators, 2 Recorders, and 1 Crowd Controller)</i>		
<b>9. Have the personnel at this level been trained?</b> <i>(Tick "YES" if you observe records confirming training of all the personnel for the campaign)</i>		
<b>10. Has an operation unit been set up for this campaign at this level?</b> <i>(Region and Council level must have an operation team to coordinate preparation; implementation and daily feedback for the campaign. Tick "YES" if you are convinced that the operation team has established).</i>		

#### B. SOCIAL MOBILIZATION

**11. Is there a plan for social mobilization at this level?**  
*(Tick "YES" if you see the plan for social mobilization at the Council level that includes health facility level religious, community leaders and plans for reaching hard to reach and minority communities)*

**12. Is there a functional social mobilization committee at this level?**  
*(Tick "YES" if you observe a copy of the minutes of the committee in preparation for the IMRC)*

**13. Is this level up to date in the implementation of planned social mobilization activities?**  
*(Review the social mobilization activities with the Focal Person at this level to see if planned activities have been or are being implemented as planned. Tick "YES" if you are convinced that activities are being implemented as scheduled)*

**14. Has high-level management met and discussed on the IMRC at this level?**  
*(Tick "YES" if you observe a record of any high level management meeting with all stake holders)*

**15. Are IEC materials available e.g. banners, posters, flyers, FAQs, Q&As etc**  
*(Tick "YES" if material(s) are available.)*

**16. Do members of the general public know the campaign dates?**

---

**17. Were community dialogue sessions held** *(Tick YES only if you attended or the reporter gave details on where, when, who facilitated, issues raised and decisions)*

---

**C. LOGISTICS**

**17. Have vaccines, diluents, AD syringes, reconstitution syringes and safety boxes been distributed as bundled (i.e. all together), to the lower level?**  
*(Tick "YES" if you observe records of distribution of vaccines, devices and diluents to the lower levels and are satisfied that lower levels were supplied an equal number of vials of vaccines and diluents)*

**18. Have tOPV been distributed as required to the lower level?**  
*(Tick "YES" if you observe records of distribution of tOPV to lower levels and are satisfied that lower levels were supplied an equal number of vials of vaccines and diluents)*

**19. Has this level made adequate arrangements to meet the transport requirements of the IMC operation?**  
*(Tick "YES" if you are satisfied with the arrangements made)*

**20. Based on the micro-plan and count of available supplies, fill the table below.**

Supply	Number Required	Number Available	Adequate?= (Yes/No)
Vaccine carriers			
Ice Packs/cool water packs for vaccine carriers			
Cold box			
Ice packs/cool water packs for cold box			
Auto-disable syringes/needles			
Reconstitution syringes/needles			
Safety boxes			
Tally sheets			
Summary sheets			
Cotton wool			
Markers			
Emergency kits			
Forms for AEFI			
Bucket and plastic bags			

**20. Has this level made adequate arrangements for the disposal of used needles/syringes and other wastes?**  
*(Each level is expected to have a waste management plan. Request for this plan and confirm that the site for disposal has been prepared and waste management staff assigned and trained) ;*

**REMARKS:**

#### Annex 4: Implementation Supervisory Checklist

TANZANIA INTEGRATED MEASLES RUBELLACAMPAIGN (IMRC)

#### INSTRUCTIONS:

This is an **implementation process** checklist to supervise the quality of implementation of IMRC at the vaccination post and the immunization service area. Every supervisor all levels must use this checklist at each visit to any post. As much as possible, application of this checklist should not interrupt services at the post.

Name of Supervisor \_\_\_\_\_ Title \_\_\_\_\_ Date: \_\_\_\_\_

Region \_\_\_\_\_ Council \_\_\_\_\_

Health facility \_\_\_\_\_ Vaccination post: \_\_\_\_\_

A. COLD CHAIN		Yes	No
<b>1. Is the cold chain system appropriately maintained at this level?</b>			
<i>Tick "YES" if: Where the vaccination post have two vaccine carriers or cold boxes and one is solely dedicated only for storing the vaccines with ice packs and the ice packs are frozen and second one used in the immunization process with adequate number of vaccines for that particular post. .</i>			
<b>2. Is vaccine and diluent in use are stored in the second vaccine carrier with frozen ice packs\ cool water packs?</b>			
<i>Tick "YES" if the vaccine and diluent are stored appropriately in the second vaccine carrier with frozen ice packs or water packs which are cold on touch. The vial being used is placed on a foam pad inside a vaccine carrier.</i>			
B. AVAILABILITY OF COMMODITIES AND SUPPLIES		Yes	No
<b>Complete the table below and then answer questions 3 to 11</b>			
<b>Supply</b>	<b>Number Available</b>		
a) Vials of MR vaccines			
b) Vials of MR diluents			
c) Auto-disable syringes/needles			
d) Reconstitution syringes and needles			
e) Safety boxes			
f e) Tally sheets			
g) Cotton wool			
h) AEFI case investigation forms			
i) Marking pens			
j) Emergency Kits			
k) tOPV vials			
l) Vitamin A capsules(100,000 IU)			
m) Vitamin A ( 200,000 IU)			
n) Deworming tablets			
3. Is there at least a day supply of vaccines and diluents?			
4. Number of AD syringes equal to the number of doses of injectable vaccines			
5. Number of reconstitution syringes/needles equal to number of vials of injectable vaccines			
6. The number of tally sheets at least equal to the remaining campaign days			
7. Is the number of safety boxes equal to or more than amount of <b>used syringes divided by 100</b> ?			
C. POST ORGANIZATION		Yes	No
8. Are there at least 5 people at the post? Please list names:			
9. Is appropriate transport available for mobile teams and/or supervisors?			
10. Enough tables and chairs are available for use by staff at the post?			
11. Is there clear and orderly flow of clients at the post with sufficient crowd control?			

<b>D. RECORDING</b>	<b>Yes</b>	<b>No</b>
12. Is the recorder accurately recording information for each child who is receiving each interventions?		
<b>E. MONITORING OF AEFI</b>	<b>Yes</b>	<b>No</b>
13. Is there a copy of the AEFI form in this Post?		
14. The vaccinators at this post know the types of events to report? Probe		
15. The vaccinators at the post know what information to include on the form? Probe		
16. Does the vaccinators know how to manage a case of AEFI? Probe		
17. Does the vaccinators have an emergency kit or is there one at the nearest health facility?		
<b>F. INJECTION SAFETY</b>	<b>YES</b>	<b>NO</b>
18. Does the health worker demonstrate proper usage of auto-disable syringe? <i>Observe the health worker vaccinating at least 2 clients.</i>		
19. Does the health worker recap syringe after use?		
<b>G. INJECTION PRACTICES</b>	<b>Yes</b>	<b>No</b>
20. Vaccinators properly clean the vaccination area and is properly organized?		
21. Vaccinators accurately draw and give the appropriate dose of each vaccine?		
22. Vaccinators administer the vaccine at the appropriate body site?		
23. Vaccinators administer the vaccine through the appropriate route?		
<b>H. WASTE MANAGEMENT</b>	<b>Yes</b>	<b>No</b>
24. Are safety boxes appropriately assembled with no exposed flaps?		
25. No disposed syringes and needles are penetrating or otherwise exposed from the box		
26. No waste other than syringes and needles is placed in the safety box		
27. Filled Safety box is no more than ¾ full		
28. Filled up safety box is kept in a secure location away from the public		
29. Used safety boxes are closed and marked used.		
30. Vaccinators know plan for disposal of filled up safety boxes? probe		
<b>I. SOCIAL MOBILIZATION</b>	<b>Yes</b>	<b>No</b>
31. The immunization post is clearly marked		
32. The team received poster/materials and at least one is seen posted in the area		
33. Are parents/guardians being reminded by the vaccination post personnel to continue with routine immunization? <i>Tick "YES" if you observe either that clients are being counselled about routine immunization or are receiving written information about the importance of routine immunization.</i>		
34. Is the community in the service area adequately informed of campaign dates, purpose, age of children to be vaccinated and location of immunization posts?		
<b>J. COVERAGE</b>	<b>Yes</b>	<b>No</b>
35. Is the post on track to reach all children in the target area? <i>Posts are expected to vaccinate at least 350 (urban) or 250 (rural) children per day. Depending on the time of your visit, determined the number of children the group should have covered with particular emphasis on hard to reach areas and populations. Review the tally sheet for the day. Tick "YES" if you are satisfied with the number of children the group has covered so far</i>		

## Annex 5: FREQUENTLY ASKED QUESTIONS ON RUBELLA

### Q. What is Rubella?

Rubella, also called German measles, is a contagious infection caused by a virus. It usually causes a mild illness with a fine, red rash over most of the body, swollen glands, and low fever.

Rubella is common in developing country including Tanzania, but children are not vaccinated (immunized) against it.

Most people who get rubella are young adults who have not been vaccinated. A person can develop immunity to rubella by having the disease or being vaccinated.

Rubella is a mild illness in adults. But if a woman gets rubella during pregnancy, her baby is at risk for birth defects, such as heart defects, deafness, and cataracts. The illness can also result in miscarriage or stillbirth. The earlier the infection occurs in a woman's pregnancy, the greater the risk that her baby will have severe defects. Women who are not immune to rubella should be vaccinated before becoming pregnant.

### Q. What does the Rash look like?

### Q. What can I do to help relieve my child's fever?

#### Newborns and babies younger than 1 year of age:

Don't wait until dehydration develops to replace lost fluids. Offer fluids to your baby often.

- If you breast-feed your baby, nurse him or her more often.
- If you use a bottle to feed your baby, the amount of fluid you normally use in the formula should be enough to replace lost fluids. Check with your child's doctor if you think you need to feed your baby more often.
- Use an oral rehydration solution (ORS) if mild or moderate dehydration develops. The amount of ORS your baby needs depends on his or her weight and how dehydrated he or she is. You can give the ORS in a dropper, spoon, or bottle.
- If your baby has started eating cereal, you may replace lost fluids with cereal. You also may feed your baby strained bananas and mashed potatoes if your child has had these foods before.

#### Children ages 1 through 11:

- Make sure your child is drinking often. Frequent, small amounts work best.
- For children with dehydration, an oral rehydration solution (ORS) or plain water (if the child is eating food) may be used to replace lost fluids.
- Allow your child to drink as much fluid as he or she wants. Encourage your child to drink extra fluids or suck on flavored ice pops, such as Popsicles. Children ages 4 to 10 should drink at least 6 to 10 glasses of liquids to replace lost fluids.
- Cereal mixed with milk or water may also be used to replace lost fluids

### Q. What is the test for Rubella?

A rubella test is usually done for a woman who is or wants to become pregnant to determine whether she is at risk for rubella. Several laboratory methods can be used to detect rubella antibodies in the blood. The most commonly used method is the enzyme-linked immunosorbent assay (ELISA, EIA).

#### Why It Is Done

A test for rubella is done to find out if:

- A woman who is or wants to become pregnant is immune to rubella.
- A recent infection was caused by the rubella virus. The presence of IgM antibodies means a current or recent infection.
- A person has been vaccinated against rubella. The presence of IgG antibodies means immunity received through either vaccination or a past infection.
- Health professionals who are in contact with pregnant women have had rubella. A health professional who has not had rubella may need to be vaccinated to prevent the risk of spreading rubella to a pregnant woman.

Some babies born with birth defects may be tested for congenital rubella.

### **Q. Why is Immunization needed for this disease?**

Getting immunized is important for at least two reasons: to protect yourself and to protect those around you. Vaccines are the best way we have to prevent infectious disease. A successful immunization program depends on the cooperation of every person.

- Vaccinations prevent you or your child from getting diseases for which there are often no medical treatments. These illnesses can result in serious complications and even death.
- A small number of people may be susceptible to diseases, such as those with impaired immune systems. These people may not be able to get vaccinations or may not develop immunity even after having been vaccinated. Their only protection against certain diseases is for others to get vaccinated so the illnesses are less common.
- Getting immunized costs less than getting treated for the diseases that the shots protect you from.
- If exposure to a disease occurs in a community, there is little to no risk of an epidemic if people have been immunized.

## **Annex 6: FREQUENTLY ASKED QUESTIONS ON MEASLES**

### **Q. What is measles?**

Measles is a dangerous disease affecting children which spreads very quickly from child to child. It is characterized by rash, runny nose and high fever. It reduces children's resistance to illness and makes them more likely to die when they are malnourished and suffering from other diseases.

### **Q. Who can get measles?**

Measles can affect people of all age groups although children who have not been vaccinated against measles are mostly affected.

### **Q. How can I tell my child has measles?**

Signs of measles in a child are high fever, redness of eyes, cough and running nose followed by rash over the face and body within 3 days.

### **Q. Is measles a serious problem in Tanzania?**

Yes. Measles is a serious problem in Tanzania. We still experience repeated outbreaks in pockets of low vaccination. In 2006 we had big outbreak in Dar es Salaam and 2007 in Tanga with more than 34 Councils in Tanzania experiencing some outbreaks.

### **Q. How is measles transmitted?**

Measles virus is transmitted from one child to another by coughing and sneezing even before a rash is seen. It spreads very quickly and faster in crowded areas like schools, markets and homes.

### **Q. What could happen to a child that has measles?**

Measles reduces the child's ability to fight other diseases resulting in frequent illnesses. If not treated quickly and properly a child with measles can develop problems such as pneumonia, diarrhea, loss of sight, hearing brain damage and death.

### **Q. How can I protect my child against measles?**

The only way to protect your child against measles is to have the child immunized by a measles vaccine. Children should receive the measles vaccine as soon as possible after the age of nine months. If for any reason a child has not been vaccinated against measles at the age of nine months, the child should be vaccinated as soon as possible.

### **Q. What should I do if my child has measles?**

Take the child to the nearest health facility immediately for treatment and advise on how to care for the child. In addition to treatment provided it is necessary to give the child nutritious foods more frequently.

### **Q. If one child has measles; will others in the home be affected?**

Almost always any child who has not been immunized by a measles vaccine will be affected by measles.

### **Q. What action can I take if an outbreak of measles occurs in my community?**

Raise community awareness on measles and other routine immunization services. Notify the community health workers and request the community leader to urgently secure needed services from the nearest health centers, and hospitals. Keep children away from large crowds e.g. do not bring them to markets.

### **Q. Where do I take my child to be vaccinated against measles?**

Take your children to your local health facility or a designated vaccination post in your area of residence to be vaccinated against measles. This will be an opportunity for your child to receive other interventions

**Q. Is it safe to give a sick child the measles vaccine?**

Minor and common illnesses, such as diarrhea, cold and if the child is malnourished are not contraindications for vaccination. It is perfectly safe to vaccinate the child against measles.

**Why is Tanzania conducting a measles campaign to immunize children 6 months to 10 years?**

Because measles is a serious problem in Tanzania, it is important to immunize all children 6 months to 10 years at once. These are the children who have been found to be more affected by measles in Tanzania.

**Q. Why do some children who were immunized against measles get measles disease?**

Occasionally, a child who has been immunized may not develop full protection. It is therefore, important for children to receive an extra dose during the campaign.

**Q. Should a child who has already received vaccination still receive another dose during the campaign?**

Yes. Even if they have had the disease or have been vaccinated.

**Q. Do I have to pay for my child's measles vaccination?**

No, you do not have to pay. The vaccination is free of charge.

**Q. Is the measles vaccine safe for my child?**

Yes, the measles vaccine is safe and will not harm the child. If the child gets fever after the vaccination, do not get worried, the fever will go away within a day. Some children may develop a rash which disappears soon.

## **Annex 7: Frequently Asked Questions and Answers on POLIO**

### **Q. Why repeated rounds of OPV campaigns?**

For individual protection, every child during the first year of life should receive at least three doses of tOPV (routine doses). Like any other vaccine tOPV is not 100% effective. Even children who have received all routine doses and supplemental polio doses can get the disease. The only way to completely eliminate the risk of getting children paralysed by polio is to completely interrupt the circulation of wild poliovirus by administration of tOPV to all under-five children. Even areas that are currently polio free have to continue with NIDs/SNIDs to prevent the risk of importation of wild poliovirus into such areas.

### **Q. Does administration of OPV have any side effects? Does it lead to illness in any child?**

No, OPV does not have any side effects and it does not lead to any illness. Many children get sick every day due to different diseases and if these diseases occur after mass OPV campaigns it is mere coincidence.

### **Q. Should OPV drops be given to newborn children?**

Yes, OPV drops must be given to newborn children also, even if they were born only a few hours ago.

### **Q. Why do we need to give OPV to children who have received routine OPV doses?**

Routine OPV drops are given for individual protection of the children against polio. However, like most vaccines OPV is not 100% effective. Some children do not develop complete immunity in spite of receiving all OPV doses. The only way to protect all children from polio is by stopping the circulation of wild poliovirus from the environment. This is possible only if all children less than 5 years of age receive additional OPV doses simultaneously as is done during the NIDs/SNIDs. This helps to interrupt circulation of wild poliovirus and thus eradicates polio. This is the only way to ensure that all children are safe and will not get polio.

### **Q. Should a child having diarrhoea or other sickness be given mOPV drops?**

OPV drops must be given to all children even those who have diarrhoea or other sickness.

### **Q. Does administration of OPV interfere with administration of drugs or antibiotics being given to a sick child?**

No, administration of OPV does not interfere with administration of other drugs or antibiotics.

### **Q. Can an overdose of oral polio vaccine be given accidentally and what would be the consequences?**

There is no danger of overdose. Multiple doses do not cause adverse reactions.

### **Q. How long will Supplementary Polio rounds continue? Will immunization activities stop soon?**

Polio Immunization campaigns will continue for the next few years even after the last case is seen to ensure that polio is really gone till we are able to certify that polio has been eradicated completely from the whole world.

The emphasis for Tanzania is to conduct campaign in high risk areas for importation, poor surveillance and low OPV coverage

## Annex 8: Regional Integrated Measles Rubella Campaign macro budget

Regional Integrated Measles Campaign Macro budget							
Region							
Planned dates of SIAs:		Oct-11					
Target population for the measles campaign:							
Line No	Items	Number / quantity	Unit Description	Number of Days	Cost / Unit	Total Amount	% of total ops costs
<b>1 Human resources and incentives</b>							
1.1	Vaccinators		vaccinator				#DIV/0!
1.2	Vaccinators - hard to reach areas		vaccinator				#DIV/0!
1.3	Recorders		recorder				#DIV/0!
1.4	Council Coordinating Team		supervisor				#DIV/0!
1.5	Council Team Supervisors		supervisor				#DIV/0!
1.6	Council Team Supervisors Rural areas		supervisor				#DIV/0!
1.7	Regional Supervisors		supervisor				#DIV/0!
1.8	Independent monitors		monitor				#DIV/0!
			<b>Sub Total</b>				#DIV/0!
<b>2 Micro planning and training</b>							
2.1	Council micro planning		session				#DIV/0!
2.2	Council implementation training		session				#DIV/0!
2.3	Training of vaccinators and volunteers and community L		session				#DIV/0!
2.4	Training of independent monitors		session				#DIV/0!
			<b>Sub Total</b>				#DIV/0!
<b>3 Transportation and logistics</b>							
3.1	Fuel for Vaccine distribution districts and facilities		vehicle				#DIV/0!
3.2	Implementation Regional Drivers		persons				#DIV/0!
3.3	Implementation District Drivers		persons				#DIV/0!
3.4	Fuel cost for Regional Supervisors		vehicle				#DIV/0!
3.5	Fuel for District Supervisors		vehicle				#DIV/0!
3.6	Fuels for Local Supervisors		motorcycles				#DIV/0!
3.7	Hiring Boats		pcs				#DIV/0!
			<b>Sub Total</b>				#DIV/0!
<b>4 Social mobilisation and communication</b>							
4.1	PHC meeting at regional,Council and facility levels		meeting				#DIV/0!
4.2	Community Mobilization Leaders		Mobilizers				#DIV/0!
			<b>Sub Total</b>				#DIV/0!
<b>5 Other Operational Costs</b>							
5.1							#DIV/0!
5.2							#DIV/0!
			<b>Sub Total</b>				#DIV/0!
<b>Total funds required for operational costs</b>							
<b>Operational cost per vaccinated child in Tshs</b>						#DIV/0!	
<b>Funds available at for operational costs (excluding vaccines)</b>						<b>Total</b>	
<b>Source:</b>							
<b>Source:</b>							
<b>Source:</b>							
<b>Source:</b>							
<b>Total available funds for operational costs</b>							

Annex 9a: MEASLES RUBELLA TALLY SHEET

TALLY SHEET - MEASLES RUBELLA VACCINE ONLY C1A

<input type="checkbox"/> Fixed Post	<input type="checkbox"/> Temporary Post	Date .....	..... / .....	Post Team Supervisor																															
<b>Council:</b>		MR Vaccines Vials Received	MR Vaccines Vials Used	MR vaccines vials returned																															
<b>Health Facilities</b>		MR Diluents Received	MR diluents used	MR diluents returned																															
<b>Vaccination Post</b>		Ad syringes Received	Ad syringes used	Ad syringes returned																															
<b>Supervisor:</b>		5mls syringes Received	5mls syringes used	5mls syringes returned																															
		Safety boxes received	Safety Boxes Used	Safety Boxes returned																															
ALWAYS CHECK VVM STATUS		<input type="checkbox"/> 1- USE	<input type="checkbox"/> 2- USE	<input type="checkbox"/> 3- DO NOT USE	<input type="checkbox"/> 4- DO NOT USE																														
<b>A</b>		<b>6 - 59 Months Old</b>																																	
		<b>B</b>																																	
		<b>60 Months - 14 Years Old</b>																																	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18																		
15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36														
29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54										
43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72						
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108
109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144
145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180
181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216
217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252
253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288
289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324
325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	<b>TOTAL (A) =</b>				<b>TOTAL (B) =</b>													
<b>TOTAL Measles Rubella (A+B)</b>																		<b>Signature:</b>																	

Annex 9b: OPV TALLY SHEET

**TALLY SHEET - OPV ONLY C1B**

Fixed Post <input type="checkbox"/>		Temporary Post <input type="checkbox"/>		Date ..... / ..... / 2014		Post Team Supervisor .....																									
<b>Council:</b>		OPV Vials Received		OPV Vials Used		OPV vials returned																									
Health Facilities		Droppers Received		Droppers used		Droppers returned																									
Vaccination Post																															
Supervisor:																															
ALWAYS CHECK VVM STATUS			1- USE		2- USE		3- DO NOT USE																								
			4- DO NOT USE																												
<b>0 - 59 Months Old</b>																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96
97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128
129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192
193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256
257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288
289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320
321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352
353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384
385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416
417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448
449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480
<b>TOTAL OPV</b>																												<b>Signature:</b>			

Annex 9c: VITAMIN A TALLY SHEET

**TALLY SHEET - MEBENDAZOLE ONLY C1D**

Fixed Post <input type="checkbox"/>		Temporary Post <input type="checkbox"/>		Date .....	..... / 2014	Post Team Supervisor																									
<b>Council:</b>		Mebendazole 500mg received		Mebendazole 500mg Used																											
<b>Health Facilities</b>		Mebendazole 500mg returned																													
<b>Vaccination Post</b>																															
<b>Supervisor:</b>																															
<b>12 - 59 Months Old</b>																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96
97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128
129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192
193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256
257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288
289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320
321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352
353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384
385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416
417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448
449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480
481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512
<b>TOTAL Mebendazole</b>				<b>Signature:</b>																											

Annex 9d: MEBENDAZOLE TALLY SHEET

TALLY SHEET - VITAMIN A ONLY C1C

Fixed Post <input type="checkbox"/>	Temporary Post <input type="checkbox"/>	Date .....	..... / 2014	Post Team Supervisor	.....																										
Council: Health Facilities		Vit A 100,000 IU received	Vit A 100,000 IU used	Vit A 100,000 IU returned																											
Vaccination Post		Vit A 200,000 IU received	Vit A 200,000 IU used	Vit A 200,000 IU returned																											
Supervisor:																															
<b>6 - 59 Months Old</b>																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96
97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128
129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192
193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256
257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288
289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320
321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352
353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384
385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416
417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448
449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480
481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512
<b>TOTAL Vitamin A</b>				<b>Signature:</b>																											

**Annex 9c: HEALTH FACILITY SUMMARY FORM**

IMMUNISATION AND VACCINES DEVELOPMENT - MINISTRY OF HEALTH AND SOCIAL WELFARE - r 1

**HEALTH FACILITY SUMMARY FORM**

N°	Vaccination Posts VARIABLES FOR CALCULATING INDICATORS	Team 1		Team 2		Team 3		Team 4		Team 5		Total for HF	
		No.	%	No.	%								
<b>1</b>	<b>Vaccination Strategy (Fixed/Temporary)</b>												
1	Number of targeted children vaccinated - Measles Rubella												
2	Number of targeted children vaccinated - OPV												
3	Number of targeted children received - Vitamin A												
4	Number of targeted children received - Mebendazole												
5	Number of target age children aged 9 Months to 14 years being vaccinated with Measles Rubella												
6	Measles Rubella vials received												
7	Measles Rubella vials Used												
8	Measles Rubella Vials returned												
9	OPV vials received												
10	OPV vials Used												
11	OPV Vials returned												
12	Ad syringes received												
13	Ad syringes used												
14	Ad syringes returned												
15	5ml Syringes received												
16	5ml Syringes used												
17	5ml Syringes returned												
18	Safety boxes received												
19	Safety boxes used												
20	Safety boxes returned												
21	Safety boxes received												
22	Vitamin A 100,000 IU capsules received												
23	Vitamin A 100,000 IU capsules used												
24	Vitamin A 100,000 IU capsules returned												
25	Vitamin A 200,000 IU capsules received												
26	Vitamin A 200,000 IU capsules used												
27	Vitamin A 200,000 IU capsules returned												
28	Mebendazole 500mg received												
29	Mebendazole 500mg used												
30	Mebendazole 500mg returned												
31	Reported AEFIs												

**Annex 9f: COUNCIL SUMMARY FORM**

IMMUNISATION AND VACCINES DEVELOPMENT - MINISTRY OF HEALTH AND SOCIAL WELFARE - r 2

**COUNCIL SUMMARY FORM**

N°	HEALTH FACILITY VARIABLES FOR CALCULATING INDICATORS	Fixed Posts		Mobile Posts		Total for District	
		No.	%	No.	%	No.	%
<b>1</b>	<b>Total number of vaccination posts</b>						
1	Number of targeted children vaccinated - Measles Rubella						
2	Number of targeted children vaccinated - OPV						
3	Number of targeted children received - Vitamin A						
4	Number of targeted children received - Mebendazole						
5	Number of target age children aged 9 Months to 14 years being vaccinated with Measles Rubella						
6	Measles Rubella vials received						
7	Measles Rubella vials Used						
8	Measles Rubella Vials returned						
9	OPV vials received						
10	OPV vials Used						
11	OPV Vials returned						
12	Ad syringes received						
13	Ad syringes used						
14	Ad syringes returned						
15	5ml Syringes received						
16	5ml Syringes used						
17	5ml Syringes returned						
18	Safety boxes received						
19	Safety boxes used						
20	Safety boxes returned						
21	Safety boxes received						
22	Vitamin A 100,000 IU capsules received						
23	Vitamin A 100,000 IU capsules used						
24	Vitamin A 100,000 IU capsules returned						
25	Vitamin A 200,000 IU capsules received						
26	Vitamin A 200,000 IU capsules used						
27	Vitamin A 200,000 IU capsules returned						
28	Mebendazole 500mg received						
29	Mebendazole 500mg used						
30	Mebendazole 500mg returned						
31	Reported AEFIs						

**Annex 10: AEFI Case Investigation Form**  
**MINISTRY OF HEALTH AND SOCIAL WELFARE**

**ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) CASE INVESTIGATION FORM (1)**  
**THIS COMPULSORY NOTIFICATION AND PLEASE COMPLETE ALL INFORMATION IN FULL**

**EPID NUMBER:** \_\_\_ - \_\_\_ - \_\_\_ - Date received at national Level \_\_\_/\_\_\_/\_\_\_

**Country      Region      District      Year Onset      Case number**

**IDENTIFICATION**

District.....Region..... Health Facility.....

Name of Vaccination Post.....Village's .....

Name.....Town/City.....Urban/Rural.....

Address.....Name of Patient/Diseased.....

Father's/Mother's name..... Telephone Contact.....

Date of Birth.....Age in years.....months..... Sex;**F/M**.....

**NOTIFICATION / INVESTIGATION**

Notified by..... Date Health facility Notified.....

Date District Notified.....Date Case/Death Investigated...../...../.....

**HISTORY**

<b>Date of vaccination</b>	<b>Name of vaccine</b>	<b>Batch No</b>	<b>Manufacturer</b>	<b>Expiry Date</b>	<b>Number of Doses Received</b>
	BCG Vaccine				
	BCG Diluent				
	OPV Vaccine				
	Pentavalent Vaccine				
	PCV-13				
	Measles Vaccine				
	Measles Diluent				

Time lapse between Vaccination and first symptom (Days...../Hours.....)

Clinical Presenting signs and symptoms (From first to Last)

.....

Time the patient was brought to H/F attention..... Prior similar history in the past..... Yes/No

Management to the patient (Before death) .....

**MINISTRY OF HEALTH AND SOCIAL WELFARE**  
**ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) CASE INVESTIGATION FORM (2)**

**SPECIMEN TAKEN**

Blood **Yes /No** ; Vaccine implicated **Yes/No** ; Diluent used/similar batch number .....Yes /No

Any clue as to possibility of contamination Yes/No; Signs of contamination.....

.....  
 .....

**PHYSICAL OBSERVATION REMARKS**

<b>Item</b>	<b>Condition at vaccination post</b>	<b>Condition at Health facility</b>	<b>Condition at District vaccine store</b>	<b>Condition at regional vaccine store</b>
Vaccine				
Diluents				
Environment at these sites				

**FOLLOW UP OF AEFI (30 days)**

Not Improved: **Yes/No**

Improved alive: **Yes/No**

Dead: **Yes/No**

Postmortem Done: **Yes/No**

**COMMUNITY OUTCOME**

Refraining from vaccination: **Yes/No**

Postmortem result

**FINAL CLASSIFICATION OF CASE:**

.....

**INVESTIGATOR**

**Name:**..... **Title:** .....

**Unit:**..... **Address:** .....**Phone** .....

**PLEASE SEND COPY OF THIS COMPLETED FORM IMMEDIATELY TO**

**IVD CENTRAL OFFICE, DAR ES SALAAM**

*If you have any question; please contact Phone/Fax +255-22-2450089*

## Laboratory Request Form

<b>This form should be sent with specimens to the laboratory and be completed by the person sending the specimens</b>
Country
Referring Health Facility
Patient's Full Name
Date of Birth*
District
Sub county
Parish
Village / LC 1
Guardian's Name
Occupation
Date of vaccination
Suspected vaccine/product
Date of onset of symptoms of AEFI
Date of collection of specimen sent
Name of laboratory where specimens are being sent
Date specimen(s) sent to the laboratory
Precise description of the samples (e.g ampoule, syringe, stool, blood, pus swab, culture tube)
How were the specimens shipped (e.g with dry ice, ice-pack)
Tests requested
Preliminary clinical diagnosis (working hypothesis)
Name of person to whom laboratory results should be sent
Complete address
Telephone number
email address
Fax number
*If date of birth is unknown, try to indicate year and if possible month of birth



