Guidelines for improving coverage of migratory/mobile populations

1. Introduction:

The number of polio type 1 cases in both UP and Bihar are at a record low level with no case having been reported in Bihar since October 2009 and in UP since November 2009. However polio type 1 cases continue to be detected often in migrant areas of polio-free states. Seven polio type 1 cases – two each in Jharkhand and Punjab and one each in Nasik, Murshidabad and Jammu have been detected since September 2009. It is well established that the migrant and mobile communities are responsible for the movement of the wild poliovirus not only between the endemic states of UP and Bihar but also between the endemic states and polio-free states. It is also documented that these populations have the potential to sustain transmission for long periods as evidenced by the genetic sequencing of the recent poliovirus isolates from UP and Bihar and non-endemic states such as Punjab, West Bengal, Maharashtra and Haryana. The occurrence of recent type 1 cases in the migrant communities of the polio-free states, therefore, poses a great risk of continued circulation of the poliovirus type 1 in India with the added risk of re-introduction of the polio type 1 virus into the endemic states.

2. Why migrant/ mobile populations are a risk for continuing poliovirus transmission?

- Children of migrants are not adequately protected, often missing out on routine and supplementary immunization rounds while on the move.
- They are at greater risk of carrying and spreading the polio virus as they transit through areas with virus circulation.
- Migrant children receive less OPV doses per year as compared to other children living in endemic areas hence they dilute population immunity when they move into endemic areas. This may contribute to persistence or reintroduction of WPV circulation in the endemic areas.

3. Characteristics of migratory/ mobile settlements:

The following migratory settlements are commonly recognized:

- **Slums with migration:** Settlements in urban/periurban areas such as Malin Basti or Harijan Basti or slums situated close to industrial area including mining/ stone crushing sites or agriculture fields. These settlements are typically found listed as slums with urban development or district authorities. Theses areas are densely populated with substandard housing, which may be Pucca or Kaccha (jhuggies), and invariably have poor sanitation. Some of these areas are unauthorized and /or are not recognized by urban development authorities. The socio economic status of the residents in these areas is low.
- **Construction sites:** Migrant families living in sites where construction is going on. Generally they live in jhuggies or brick sheds in and around the under-construction buildings. The number of families and children present in these sites vary according to the size of the construction site.
- **Brick kilns**: Migrant labour camping in brick kilns and the "Pather" fields where raw bricks are prepared.
- **Nomads**: Populations such as Mangtey, Kanjar, Fakirs, Natts, Banjara, Shah, Shahbali, Albi, Gadhia Luhar, Ghumantu etc. often moving from place to place for livelihood, usually setting up "dera" wherever they stop. They are normally found in between or at the end of big colonies, railway stations, along the rail tracks, open fields, market places and in urban/ periurban slums.

4. Key Actions for improving coverage of migratory/mobile populations during polio campaigns:

a. **Identifying and listing all sites with migratory/ mobile populations**:

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- A district level meeting should be organized with participation of Medical Officer incharges from urban area and PHCs catering to periurban areas. The meeting should be facilitated by Chief Medical Officer /Civil Surgeon/District RCH Officer, DIO and SMO from NPSP. The meeting should discuss the steps to be taken at the Urban health centres /PHCs for identification and coverage of the migratory/ mobile populations

- All Block PHCs/PHCs/Urban Health Centres should identify and map pockets of migratory/ mobile settlements in their area. Medical Officers should list all migratory settlements as characterized above with the help of health/ICDS/ sanitation workers such as ANMs, Health Supervisors, Polio supervisors, ASHAs, Anganwadi workers and sanitation workers. The workers must walkthrough their areas, particularly the urban and periurban areas, to identify all pockets of migratory populations and estimate the number of households and target population. If the migratory areas are a part of the polio micro-plans this data may also be collected from previous SIA rounds in the area.

- A template for identifying and listing areas with migrant/ mobile populations (planning form 1) should be used for identifying and listing of these populations.

b. Preparation of micro-plans for coverage of migratory populations:

- The number of vaccinators and supervisors required to conduct h-t-h activity in each area should be estimated using planning form 1.

- Each vaccination team should have 2 members and each supervisor should supervise 5 teams. On an average, each vaccination team should visit 125-150 households per day. The duration of activity should depend on the number of households and availability of manpower. The activity should nevertheless be completed within 2-5 days from the start. Information on manpower should be collated on planning form 2.

- Each team should have a well defined area to cover each day with the number of households expected to be covered. A micro plan giving details of each teams work area for each day should be prepared on planning form 3 by the supervisors and medical officers.

- Mobile teams should be planned for areas with sparse populations, small clusters of floating migratory populations. Each mobile team should have independent mobility, should cover multiple such areas and a detailed route plan of the areas to be covered by each team each day should be made using planning form 4.

- The best vaccinators from amongst the health workers, ASHA and Anganwadi workers should be deployed to cover these areas. All supervisors must be independently mobile.

- Estimates of OPV requirements and vaccine carriers should be made for each area with migratory population and recorded in planning form 5. This should be collated by the supervisors and medical officers based on field experience and from coverage of these areas during past SIAs.

- Planning should be undertaken for preparation and timely display of sufficient IEC materials for these areas to ensure awareness of the campaign among these communities.

- Planning should be undertaken for logistics such as tally sheets, OPV vial openers, indelible election ink marker pens, chalk etc. The total number of vehicles required for transport of vaccine, transport of mobile teams and transport of supervisors should be estimated and recorded on planning form 6.

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- Supervisors and vaccinators should be oriented before the round in batches of 40 – 50 vaccinators per session. The orientation should cover the operational as well as the interpersonal communication aspects to enable the vaccinators to handle questions frequently asked by the community

- Planning forms 1 to 6 should be prepared by each urban area/PHC and the information then collated at the block/district/state level on similar formats. State officials should review the data submitted

c. Reviewing preparedness: District Task Force meeting

District task force meetings should be organized in each district to identify issues and discuss actions to ensure high quality implementation of the programme in the high risk areas with migratory/mobile populations. At least one DTF should be organized before each round to discuss issues and improve quality

d. Implementation of polio campaign in areas with migrant/ mobile populations:

- *Vaccination teams must visit these areas at the time when children are most likely to be available at their homes - either early morning or late evening since children at these sites accompany their parents to work.*

- All children less than 5 years of age should be administered OPV drops and marked on their left little finger **with indelible election ink (silver nitrate based) marker pen.**

- All house to house and mobile teams should mark all houses as P & X as per existing guidelines.

- Vaccination teams should use tally sheet and record X houses on the back of the tally sheet.

- Data generated by teams and supervisors should be compiled and submitted in reporting forms.

- District and urban area supervisors should ensure that all teams are supervised to ensure high quality coverage in these areas

5. Preparation of micro-plans for coverage of migratory/mobile populations during routine immunization sessions:

Special efforts must be undertaken to include and cover the migratory/ mobile high risk areas (HRAs) with routine immunization. Routine immunization microplans must incorporate all migratory HRA sites and organize fortnightly or monthly outreach routine immunization sessions at these sites because they have a high turnover of families. Since families and children may not be available for coverage during routine working hours teams should cover these areas either early in the morning or late in the evening. Medical officers and district officials should monitor these activities.

6. Monitoring by State & District level Officers

State and district officials should be assigned areas with large migratory/ mobile populations. They should visit these areas to assess preparedness and supervise implementation of polio campaigns and RI.

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