

OPERATIONAL GUIDE FOR PULSE POLIO IMMUNIZATION IN INDIA

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1. BACKGROUND

1.1 Introduction :

Tremendous progress has been made since polio eradication activities were first introduced in 1995. India is now recording the lowest levels of polio virus transmission ever, and is poised to completely interrupt transmission in the very near future. From the beginning of the polio eradication initiative, India has been the world's largest polio endemic country. Before the introduction of National Immunization Days (NIDs) in 1995, an estimated 35,000 children were paralysed by polio in India each year. Significant reductions in cases were seen mainly as a result of the implementation of NIDs in the following years, but in 2002, 1600 cases were reported in a major outbreak that originated in western Uttar Pradesh (UP) and spread into many other states most of which had been polio free for more than one year.

The polio partnership in India under the leadership of Government of India (GOI), mounted an appropriate response to the outbreak. The number of Supplemental Immunization Activities (SIAs) was increased and improvements made in SIA quality and community acceptance of the vaccine through enhanced social mobilization efforts including a special Under Served Strategy for areas of western UP. The outbreak was controlled and disease curtailed in just two years from 1600 cases in 159 districts in 2002 to 134 cases in 44 districts in 2004. The programme has continued to build on these achievements and also introduced the monovalent oral polio vaccine (mOPV) which has further reduced the number of polio cases to 66 in 2005 (as of 14.02.06). Of the 66 polio cases in the country, 30 cases were from Bihar, 29 from western UP, 2 from Jharkhand and 1 each from Delhi, Uttaranchal, Punjab, Haryana and Gujrat. Although no cases were detected in Mumbai/Thane areas, sewage samples detected the presence of wild polio virus which was genetically linked to virus in Bihar. This is the lowest number of polio cases ever detected in a year in the country (Fig. 1.1). There has been a continuous reduction in type 3 polio virus cases also which is now almost eliminated, decreasing from 22 cases in 2003 to 7 in 2004 and 4 in 2005 (all in a localized area in western UP).

The progress since 2003 is the most significant in the history of polio eradication in India. The reduction in reported polio cases from 2003 to 2005 has occurred against a background of significantly improved surveillance sensitivity. Enhanced sensitivity has enabled rapid identification of areas of transmission which are targeted for intensive SIAs to eliminate the last chains of transmission.

1.2 Supplementary Immunization Activities in 2005:

Two NIDs were conducted in the months of April and May 2005, covering more than 170 million children in each round. In addition, 6 SNIDs were conducted in the highest risk states. In an attempt to completely stop circulation of type 3 virus two special rounds - one in July 2005 using trivalent OPV (tOPV) and another

in December 2005 using monovalent OPV3 (mOPV3), were additionally conducted in some districts of west UP where wild polio virus type 3 cases were detected.

WHO's Advisory Committee on Polio Eradication (ACPE) in their meeting held in September 2004 had recommended that in situations of persisting type 1 transmission in spite of reasonably good SIAs (as was happening in India and Egypt), the use of mOPV1 which is highly potent against type 1 virus, may be considered. In view of this recommendation, use of mOPV1 was started in India in April 2005 NID in the high risk districts of western UP, Bihar and Mumbai/Thane. This was continued in May NID and SNIDs from August to November in high risk areas. Between April and November 2005 four to six mOPV1 rounds were conducted in these areas. The introduction of mOPV1 had a positive impact in all areas (Fig. 1.2).

India is now faced with the challenge to eradicate poliovirus in 2006 by further enhancing the quality of the SIA rounds and reaching every child especially new borns and young children. The aim of all supplementary immunization efforts is to ensure that all children below 5 years are reached and vaccinated during each round, which calls for ensuring highest level of commitment, competence, hard work and enthusiasm. A sense of urgency must be maintained at all levels to perform high quality NIDs/SNIDs. It is important that special efforts are made during the upcoming NIDs/SNIDs in the remaining reservoir areas to break the last vestiges of transmission. It is also extremely important to ensure high quality NIDs in the entire country to achieve nationwide immunity. This will safeguard the country from establishment of polio virus circulation in polio free areas in the event of introduction of the virus.

**It is imperative to have highest quality NIDs/SNIDs
to stop poliovirus transmission in India**

Location of wild poliovirus - India

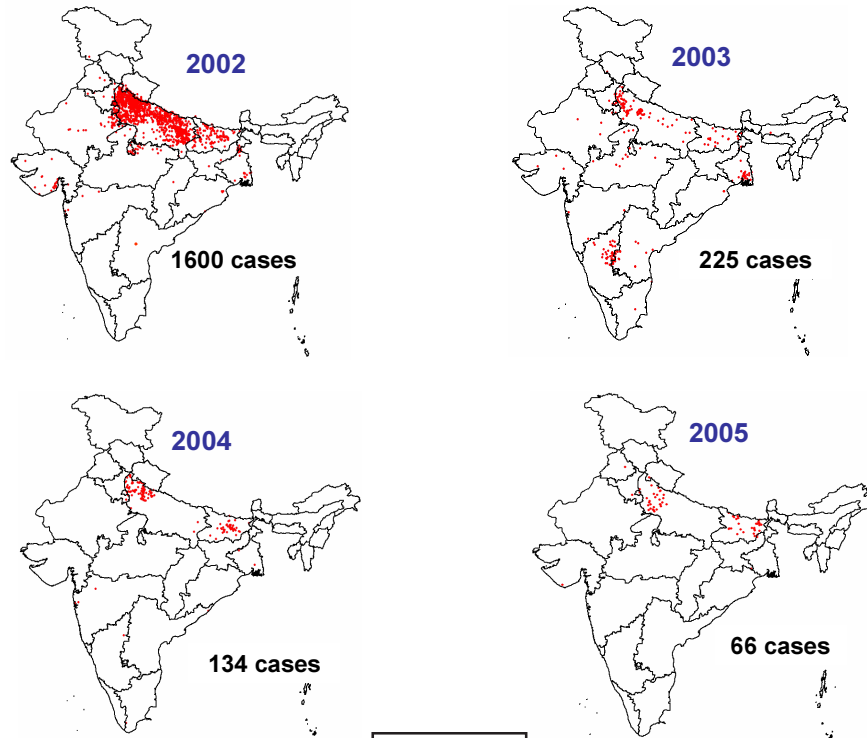


Fig. 1.1

Incidence of polio cases-U.P, Bihar

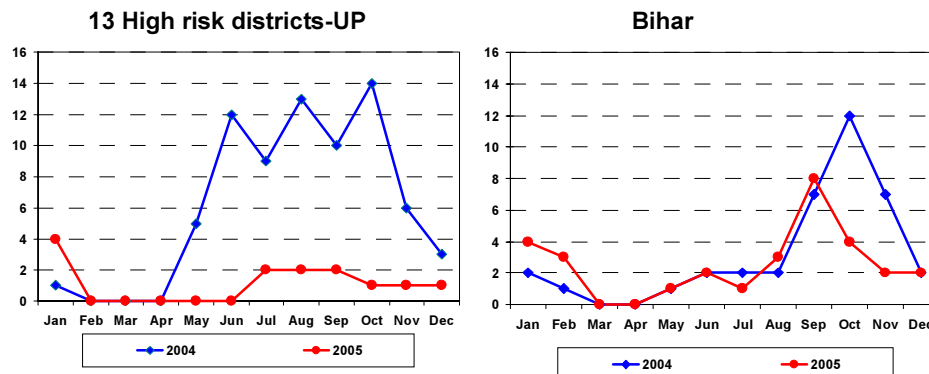


Fig. 1.2

2. THE EPIDEMIOLOGY OF POLIO

2.1 The Polioviruses :

The polioviruses are three related enteroviruses : types 1, 2, and 3. All three types cause paralysis. Type 1 causes paralysis most frequently. The type 2 virus has not been detected worldwide since October 1999. Type 3 virus is now restricted to western UP in India.

2.2 Communicability and Transmission :

Poliovirus is highly communicable. The time between infection and onset of paralysis (incubation period) is 7-10 days (range 4 - 35 days). Transmission is primarily person-to-person via the faecal-oral route; i.e. the poliovirus multiplies in the intestines and is spread through the faeces. The virus is intermittently excreted for one month or more after infection. Communicability of infected children is highest just prior to the onset of paralysis and during the first two weeks after paralysis occurs. The virus spreads rapidly and transmission is usually widespread by the time of paralysis onset. There is no long-term carrier state in normal children.

The transmission and seasonality of poliovirus is similar to other gastro-intestinal diseases like diarrhoea and typhoid. An infected individual will probably infect all other non-immune persons in the neighbourhood, especially where sanitation is poor.

2.3 Immunity :

Protective immunity against poliovirus infection develops by immunization or natural infection. Immunity to one poliovirus type does not protect against other poliovirus types. Immunity following natural infection or by live oral polio vaccine (OPV) is believed to be lifelong. Infants born to mothers with high antibody levels against poliovirus are protected for the first weeks of life.

2.4 Occurrence :

Poliomyelitis occurred worldwide, but is now limited to Asian and African continents. Presently the disease is endemic in 4 countries in the world namely India, Nigeria, Pakistan and Afghanistan. Importations from these endemic countries were reported in other polio free countries with cases occurring in Yemen, Indonesia, Somalia, Ethiopia, Angola and Nepal.

The disease is seasonal, with cases starting to increase sharply in June, with peaks during July through September/October. Cases continue to occur in areas with low immunization coverage, high population density and poor sanitation.

2.5 Reservoir :

Poliovirus infects only human beings and there is no animal reservoir. The virus does not survive long in the environment outside the human body. In tropical climates, the virus once excreted into the environment has a half-life of infectivity of 48 hours.

Most children infected with poliovirus do not show signs of disease since paralysis occurs only in 1 out of every 200 children infected with the virus. However, these children can pass on the virus to other susceptible children in the neighbourhood. Hence it is essential to reach every child under the age of five during every SIA round.

3 . STRATEGIES FOR POLIO ERADICATION

Polio has been eradicated from most of the world using several key strategies. Each of the following strategies are important components in the National Polio Eradication Programme :

- (a) Routine immunization: Sustaining high levels of coverage with 3 doses of oral polio vaccine in the 0-1 year age group.
- (b) Supplementary Immunization Activities (SIAs): Simultaneous administration of oral polio vaccine to all children in the age group of 0-5 years, 4-6 weeks apart to interrupt wild poliovirus transmission and to increase immunity amongst children.

SIAs include:

- ❖ National Immunization Days (NIDs) when the entire country is covered.
- ❖ Sub National Immunization Days (SNIDs) when some states or parts of states are covered.
- ❖ Mop-ups are conducted, as soon as possible after identification of the virus as an end game strategy to interrupt transmission, when virus transmission is focalized and polio cases are found in specific areas.

The basic aim of conducting SIAs is to reach all under five children with potent vaccine in each round. The main strategy to achieve this is by offering:

- (i) Immunization to all children at booths on the first day and
 - (ii) Follow up on missed children through house-to-house immunization teams and
 - (iii) Immunize children in transit through transit teams deployed throughout the duration of booth and house to house immunization activity.
- (c) Surveillance and investigation of cases of acute flaccid paralysis (AFP).
 - ❖ Surveillance data is used to identify areas of wild poliovirus transmission and to guide immunization activities.

Polio can be eradicated if the recommended strategies are implemented effectively as has been accomplished in many countries of the world and in most states in India

4 . ORGANIZING NIDs/SNIDs

The highest level of political, administrative ownership, commitment and support needs to be sustained for successfully stopping polio virus transmission for ever. The Union Government, the State Governments, and their international and national partners need to maintain and further enhance focus and momentum. The polio eradication strategies are working and must continue to be implemented to the fullest. Any distraction or loss of quality at this stage will imperil all the strenuous efforts made to date, and risk failure at the brink of success.

4.1 Setting up of National /State /District /Block committees :

Since health departments have limited resources, the role of other departments at all levels - national, state, district and block is vital for successful implementation of the programme. **(Refer to section on roles of Government departments and other sectors.)** The Government of India has set up National level committees to ensure inter-sectoral coordination between all partners and other departments and review the progress in planning, implementation and monitoring of the programme. Before the NID/SNID such committees which may already be existing need to be reactivated at state, district and block level.

Regular scheduled meetings should be held with clear objectives, agendas, and action points from previous meetings. This should include progress, problems encountered, proposed solutions and new action points with clearly defined responsibilities and deadlines. Minutes of the meetings and action points should be shared with all the participants. The committees should ensure that activities are completed, adhering to guidelines and timeliness.

4.1.1 National level :

Steering Committee at the national level to be chaired by the Cabinet Secretary, Government of India. The role of steering committee is to:

- ❖ Coordinate activities with Government departments like Education, Social welfare, Home affairs, Defence, Youth affairs, Urban development, Railways, Civil Aviation, Shipping, Commerce etc. to mobilize human and other resources.
- ❖ Provide material support for IPPI programme in the country.

Central Operations Group comprising officials from Government of India, WHO, National Polio Surveillance Project (NPSP), UNICEF and other partners at the national level chaired by the Secretary, Family Welfare, Government of India. The role of the Central Operations Group is to meet on a regular basis to:

- ❖ Support pre-planning and to fast track decisions on extent of SNIDs and timing of NIDs/SNIDs. Decisions on extent of area to be covered under SNID/ mop-ups and type of vaccine to be used are based on epidemiological and genetic data.
- ❖ Coordinate activities with other Government departments like Education, Social welfare, Home affairs, Defence, Youth affairs, Urban development, Railways, Civil aviation, Information and Broadcasting, Shipping, Commerce etc. to mobilize human and other resources.

- ❖ Coordinate activities by agencies like WHO, UNICEF, Rotary and other NGOs.
- ❖ Monitor implementation of IEC/Social Mobilization activities at national, state and district level.
- ❖ Ensure intra departmental coordination with donor coordination division, vaccine procurement division and IEC division.

Pulse Polio Media Committee with Secretary Family Welfare, Government of India as Chairperson. The role of the media committee is to:

- ❖ Develop and finalize media plan with timeline.
- ❖ Monitor implementation of IEC/Social Mobilization activities at national, state and district level.
- ❖ Coordinate with DAVP, Song and Drama Division, Doordarshan, AIR, Field publicity etc.

4.1.2 State level :

State Steering Committee under the chairmanship of Chief Secretary. The role of the State steering committee is to mobilize human / other resources and coordinate planning and implementation activities with other departments.

State Co-ordination Committee under the chairmanship of State Family Welfare Secretary with Director/State MCH Officer as the convener. State level representatives of the key partners like social welfare, education, panchayati raj institutions, NPSP, WHO, UNICEF, Rotary, religious leaders, minority groups should be invited to attend coordination committee meetings. The role of the committee is :

- ❖ To ensure inter sectoral coordination and full utilization of resources from partner government and non government departments.
- ❖ Monitor preparedness in each district of the state.

State Pulse Polio Media Committee under the chairmanship of State Family Welfare Secretary with the State media officer as the convener. Partner organizations like UNICEF, NPSP and Rotary will be represented in the committee through their state level representatives. The role of the committee is to:

- ❖ Develop a media plan with timeline.
- ❖ Utilize all available resources and channels for delivering simple and clear messages to the community, which will help to ensure full turnout of children on the days of IPPI.
- ❖ Monitor implementation of IEC/social mobilization activities in the states.

NID/SNID control room shall be set up in each state. The control room should be set up in the office of the SEPIO/ RC/ SRC/ State SMO. The State EPI Officer, the concerned RC/SRC/State SMO of NPSP, a UNICEF representative and a nominated member from the state government should be stationed in the Control Room for planning and implementation of activities. The role of the control room should be to monitor preparedness on a day to day basis especially mobilization of human and other resources like transport, ensure inter sectoral coordination and full utilization of resources from partner government and non-government departments. It should also monitor implementation of the programme during the activity. The control room should be providing feedback to the state steering committee and state coordination committee on progress being made and also on any obstacles being faced.

4.1.3 District level :

District Task Force (DTF)/District IPPI Coordination Committee under the chairmanship of the District Collector/Magistrate/ Chief Executive Officer in each district.

- ❖ The role of the district task force is to supervise, support, monitor and ensure implementation of the highest quality NIDs/SNIDs in the district.
- ❖ DM and CMO should also use these meetings to clear obstacles for planning and implementation of the programme.
- ❖ The District Task Force should meet at least three times before the round and every day during the activity.

NID/SNID control room at District level : A control room should be set up at the district level to monitor preparedness of blocks/ PHCs/ urban areas on a day to day basis and to monitor implementation of the programme during the activity as is expected from the state NID/SNID control room.

4.1.4 Sub District level :

- ❖ Similar to the DTF, Tehsil / Block level task force should be set up under the SDMs/BDOs with similar role and objectives.
- ❖ **District Magistrates or ADMs should chair the Block Task Force meetings in the high-priority blocks**

4.2 Role of Government Officials in NIDs/SNIDs :

4.2.1 District Magistrates/ District Collector/ Chief Executive Officer :

- ❖ District Magistrates are responsible for monitoring the planning and implementation of NID/SNID activities in their districts through weekly review of the progress and problem solving.
- ❖ They shall ensure involvement and inter sectoral coordination of all other departments in the district for mobilization of manpower, transport and social mobilization, thereby ensuring that all departments function to their full potential as outlined below.
- ❖ Depute senior officials from the administration and other sectors to supervise preparations and implementation of the NIDs/SNIDs in various blocks and urban areas of the district. **All senior officials are accountable for their areas.**
- ❖ Organize and conduct meeting of religious and community leaders.
- ❖ Monitor training attendance in high risk areas.

District Magistrates should ensure involvement of staff from other Government departments as vaccination team members

**4.2.2 Chief Medical Officer/ District Health Officer/ Civil Surgeon/
District Medical and Health Officer :**

- ❖ Shall support the District Magistrate and the District task force in their roles outlined above for timely implementation of NIDs/SNIDs at the district level.
- ❖ Shall ensure review and finalization of microplans including IEC and social mobilization plans of all blocks and urban areas before start of activity.
- ❖ Shall ensure all vaccinators and supervisors have undergone orientation as and when required.
- ❖ Make supervisory visits to sub district levels to review preparedness and monitor implementation.
- ❖ Procure and distribute vaccine and other logistics.
- ❖ Release funds to blocks in time.

CMO shall be responsible and accountable for the development of micro plans of the entire district

4.2.3 District Immunisation Officer :

- ❖ Shall support the Chief Medical Officer in the role outlined above .
- ❖ Collect compile and transmit data to state.
- ❖ Analyse feedback data and present it to DTF and at District review meetings for corrective actions.

4.2.4 Block/PHC Medical officer/Nodal Officer for planning in urban areas :

Supervise development of correct microplans, and timely implementation of immunization activities during NIDs/SNIDs at the block/PHC level. This includes:

- ❖ Revising microplans for NIDs/SNIDs and their implementation.
- ❖ Identifying proper supervisors and vaccinators.
- ❖ Ensuring orientation of vaccinators and supervisors as and when required.
- ❖ Conducting meetings with community leaders/religious leaders.
- ❖ Ensuring banners /posters are displayed in time and well ahead of the activity.
- ❖ Arranging transport for delivery of vaccine and logistics and miking.
- ❖ Developing route charts for vaccine delivery and miking.
- ❖ Distributing vaccines and other logistics to teams.
- ❖ Supervising booth and house to house immunization activities.
- ❖ Collecting and compiling reports from vaccination teams and supervisors.
- ❖ Analysing and reviewing feedback /data from teams, supervisors, monitors, medical officers and plan corrective actions.

It will be mandatory for all medical officers/nodal officers to review and finalize microplans before activity and ensure their implementation during NIDs/SNIDs.

All block medical officers/urban nodal officers should be made accountable for their areas.

- 4.2.5 **Key assistants at Block/PHC like Immunisation Official/Social Welfare Officer/ Health Supervisors/Public Health Nurse/ Computer. They will :**
- ❖ Assist Block/PHC Medical Officer in his role outlined above.

4.3 Role of Govt. departments and other organizations in NIDs/SNIDs:

4.3.1 Education, NCC, NSS and NYK :

- ❖ Polio booths may be located in schools/colleges .
- ❖ School teachers/ college students can be part of booth and house to house vaccination teams and/or accompany the teams during their house to house visits.
- ❖ School children/college students should take out rallies in support of the programme prior to the NIDs/SNIDs and on days of activity.
- ❖ Schools should develop an army of school children who will identify target children in their neighbourhoods and bring them to the booths.
- ❖ Schools should display banners and posters in support of the programme .

4.3.2 Social Welfare :

- ❖ Polio booths may be located at ICDS centres.
- ❖ ICDS workers must be part of vaccination teams.
- ❖ Anganwadis should distribute and display IEC materials like handouts, posters and banners in their neighbourhood.
- ❖ ICDS workers should help in contacting local community leaders/mothers groups to raise community awareness about NIDs/SNIDs.

4.3.3 Panchayati Raj Institutions :

- ❖ Help to identify and provide suitable locations for booths.
- ❖ Help in creating community awareness about the programme.
- ❖ Gram Panchayat Vikas Adhikari (Village development secretaries), Lekhpals, Village Pradhans and Panchayat members should accompany vaccination teams during house-to-house visits and mobilize community to accept OPV. **Their participation is crucial in conversion of X houses and in areas with resistance to acceptance of OPV.**
- ❖ Give feedback on completion of activities in their areas.
- ❖ Launch the programme in their areas.

4.3.4 Railways, Surface transport, Civil aviation, Shipping :

- ❖ Departments should allow setting up of Transit booths on all railway platforms/ bus terminals /highways /ferry crossings/airports/ports during booth and house-to-house activity days. Where ever required these booths should function 24 hours, during the days of activity.
- ❖ Railway health staff should vaccinate all target children in railway staff colonies.
- ❖ OPV should be provided in selected trains linking endemic areas of the country by railway health staff.
- ❖ Polio spots should be shown on closed circuit TV at all railway stations/bus terminals/airports before and during the activity. Miking should also be done

from fixed sites at these places.

- ❖ Polio hoardings should be displayed on all railway coaches, railway stations, and bridges to create awareness.

4.3.5 Other Government departments like Home Affairs, Defence, MTNL, ESI etc.

- ❖ Should provide vehicles for the NID/SNID activity.
- ❖ Polio booths may be located in their premises
- ❖ Government workers may be part of vaccination teams and at least help to cover their own residential colonies.
- ❖ Government offices should display IEC materials like posters and banners.
- ❖ Police wireless may be used to convey urgent NID/SNID messages.
- ❖ Concerned departments should allow the key messages of NID/SNID programme to be printed on telephone, electricity and water bills.
- ❖ Telephone exchanges may be requested to play messages regarding the programme when subscribers make or receive telephone calls.

4.3.6 Professional medical bodies :

- ❖ National, state and district chapters of all professional bodies should send out a formal communication to all their members requesting them to mobilize their clients. All private and public physicians, private practitioners and other health professionals can inform their clients of the dates of NIDs/SNIDs and the need for all children 0-5 years of age to receive a dose of OPV during all NID/SNID rounds, regardless of their prior immunization status.
- ❖ All health professionals should open their clinics during the day of NIDs/SNIDs and inform their clients to bring their children 0-5 years of age for a dose of OPV.
- ❖ Display IEC materials at their clinics.
- ❖ Accompany vaccination teams to convince reluctant parents.
- ❖ Health professionals can also help to monitor the NID/SNID activities.

4.3.7 NGOs/other voluntary organizations:

- ❖ Create community awareness for NIDs/SNIDs by contacting community leaders, developing, distributing and displaying IEC materials.
- ❖ Provide transport for NIDs/SNIDs.
- ❖ Polio booths may be located at their premises.
- ❖ Help to mobilize the parents to the booth and accompany vaccination teams during house to house visits.

4.4 Meetings for NIDs/SNIDs :

To ensure that the micro-planning guidelines are followed, logistics and supplies properly arranged for, and personnel involved at all operational levels clearly understand their roles and activities to be undertaken; trainings/meetings listed below must be conducted before the NID/SNID in each district/urban area. A meetings/training plan and timeline should be included in the microplan for each state, district and block.

4.4.1 State NID/SNID planning workshop :

- ❖ The State Secretary of Health, Director Health Services and/or Director Family Welfare, SEPIO, Regional Coordinator (RC) and Surveillance Medical Officers (SMO) of National Polio Surveillance Project (NPSP), together with the Health Officer, UNICEF should facilitate these meetings.
- ❖ The meetings have to be attended by District Magistrates, Chief Medical Officers (CMO), District Immunization Officers (DIO), state level representatives from UNICEF, Panchayati Raj Institutions, Social Welfare, Education, IAP, IMA, and other agencies NGOs like Rotary.
- ❖ The objective of the meeting should be to sensitize the district level planners on the strategy to be followed, need for preparing microplans for their areas, and sort out issues of coordination between the implementing partners.

4.4.2 District Task Force Meetings :

- ❖ **Members :** The District/Chief Development officer, ADM, CMO, DIO, NPSP-Surveillance Medical Officer, UNICEF district representative wherever available, district level officials from education, transport, social welfare, revenue, BDOs, IAP/IMA representatives, representatives of medical colleges, prominent NGOs, District Information Officer and important religious leaders should be members of the DTF. Block/PHC medical officers and nodal officers for planning in urban areas should also be invited to attend the meetings whenever necessary. In districts with high density of Muslim population, Muslim community leaders should also be members of the district task force.
- ❖ The role of the district task force is to supervise, support, monitor and ensure implementation of the highest quality NIDs/SNIDs in the district.
- ❖ DM and CMO should also use these meetings to clear obstacles for planning and implementation of the programme.
- ❖ The District Task Force should meet at least three times before the round and every day during the activity.
- ❖ The District Task force is responsible and accountable for the implementation of a quality NID/SNID in the district.

4.4.3 District Micro planning Meeting/Urban Area Planning Meeting:

- ❖ The Chief Medical Officers (CMO) / District Immunization Officers (DIO) and the Surveillance Medical Officers (SMO) of National Polio Surveillance Project (NPSP) should facilitate these meetings.
- ❖ The meetings have to be attended by all block medical officers, urban health planners, social mobilization coordinators from UNICEF and other organizations involved in social mobilization, along with personnel involved in planning at the block level.
- ❖ The objective of these meetings should be to sensitize the block medical officers (BMOs) and the urban area planners on how to micro plan for their areas for the upcoming NIDs/SNIDs. Special attention should be paid on developing area-specific IEC strategies for problem pockets.

4.4.4 State /District Review Meetings:

A meeting should be organised a week after completion of NID/SNID activities to review the performance of NID/SNID activity based on the feedback from monitors, state, district and block level supervisors. Data analysis from the NID/SNID round should also be presented at this meeting. The meeting should identify actions to be undertaken for rectification of deficiencies in the next round.

4.5 Monitoring by State and District Observers:

State and District level Officers should be allotted districts / blocks/ urban areas which should be meticulously visited before the activity for monitoring the preparedness and during the activity to monitor the implementation of the activity. The observers should identify any constraints that are likely to affect the implementation of the programme and find solutions to remove any bottlenecks.

4.5.1 Preparatory phase:

All state observers should attend District and Block Task Force meetings and report back to the State Family Welfare Secretary on the quality and effectiveness of these meetings. They should also monitor whether vacancies of Medical Officers and ANMs have been filled up in the high-risk blocks/areas and assess the involvement of 'non health' government departments as vaccination team members. Observers should also review the micro plans to ensure that :

- ❖ All components are present.
- ❖ All geographical areas have been included.
- ❖ Team composition is appropriate - all house-to-house teams have at least one female vaccinator and at least one member from the same community being served. Also ensure ICDS workers are part of vaccination teams as far as possible.
- ❖ Workload of teams has been rationalized.
- ❖ Transit points have been identified and covered with teams working in multiple shifts, where ever required.
- ❖ Areas requiring special attention have been identified and plans developed to cover them.
- ❖ Trainings have been planned for all vaccinators and supervisors.
- ❖ IEC/ Social Mobilization plans have been developed and documented.

The formats 12 A to 12 E (pages 90 to 94) are to be used by monitors for the above mentioned assessment prior to the round.

4.5.2 Implementation phase:

- ❖ All officers should again visit their allotted districts / blocks/ urban areas during the implementation phase to assess the quality as also the completeness of coverage of children less than 5 years of age.
- ❖ The NPSP-UNICEF monitoring format could be used for monitoring by observers after a briefing on the methodology of monitoring just before the NIDs/SNIDs by the SMO of the district.

- ❖ It is essential to ensure a mechanism of daily feedback from the observers to the blocks and DTF to facilitate immediate corrective action at all levels. Information on missed areas, false P houses¹, X generation and false X to P conversion are useful tools for assessing quality.
- ❖ Qualitative and quantitative assessment on the immunization activity from observers should be utilized for long term corrective actions like retraining of vaccinators, review of microplans etc. or immediate corrective actions like repeating the activity in an area where significant number of unimmunized children are found after completion of activity

The formats 12 F to 12 I (pages 95 to 98) are to be used by monitors to assess the quality of implementation of the round.

1. False P house: a P marked house where vaccination teams have claimed to have immunized all children from 0- 5 years in the house, but unimmunized eligible children are detected by supervisors or monitors during their visit to the house.

5 . MICRO PLANNING AND IMPLEMENTING NIDs/SNIDs

Successful implementation of SIAs requires meticulous microplanning . Important components of microplan are as under :

- ❖ Booth activity.
- ❖ House-to-house activity.
- ❖ Transit site activity.
- ❖ Activity in high risk and underserved areas
- ❖ Activity at Brick kilns, construction sites, congregation sites, urban areas.

Besides planning and implementation of the above mentioned activities other key components of NIDs/SNIDs which require planning and implementation, are discussed in detail in chapter 6.

5.1 Booth activity :

Booths will be setup on day 1 of the NID/SNID campaign to take advantage of IEC/ Social Mobilization efforts. On this day OPV vaccine shall be provided to all children aged 0 - 5 years (including newborns) who are brought to the booth.

All departments of the government (e.g. education, social welfare, ICDS, panchayati raj institutions, civil defence, revenue etc.) as well as NGOs and the community participate to create a festive atmosphere at the booth. For this reason it is essential that adequate social mobilization (refer to the section on social mobilization) measures are undertaken prior to the NIDs/SNIDs so that parents are fully informed about the:

- ❖ Dates of immunization at the booth.
- ❖ The locations of the booths.
- ❖ The benefits of receiving OPV.

At the booths the parents should be reminded about the need for continuation of routine immunization and the date of next NID/SNID round.

5.1.1 Setting up booths :

- ❖ On an average, a booth should be catering to 250 target children.
- ❖ In densely populated areas each booth may cater to 300 - 350 target children.
- ❖ In sparsely populated areas each booth may cater to 100 - 150 target children. Each booth should normally have four trained personnel. However in sparsely populated areas, two persons may be posted at booths.

5.1.2 Location / Placement of booths:

- ❖ The booth should be located at a prominent well-known place which is easily identifiable by the community and is within easy reach of the community.
- ❖ It is not essential that booths should be located in government health

facilities only. Based on the local situation and needs, booths could be set up in non-government organizations both in health and non-health sectors like in schools, panchayat buildings, religious places etc. and at other places frequently visited by the community.

- ❖ Parents should not have to walk for long distances to reach booths.
- ❖ More than one booth should not be located in the same building/premises.
- ❖ Transit teams should also be located in crowded locations like fairs or melas, markets, bus terminals, railway stations, ferry crossings to cover transit population.
- ❖ Placement of the booths should be acceptable to all sections of the society.

5.1.3 Booth management and logistics:

Each booth should have

- ❖ One vaccine carrier with frozen ice packs (see the section on cold chain)
- ❖ Adequate OPV vials for the expected number of children (plus wastage, use wastage multiplication factor of 1.27 to calculate vaccine requirement)
- ❖ A VVM card /infokit
- ❖ Tally sheets in adequate numbers
- ❖ Pencil/pen to mark tally sheets
- ❖ Indelible ink marker pen to mark children immunized at the booth
- ❖ Small screwdriver/vial opener to remove aluminium seals of glass OPV vials
- ❖ Banner(s) and posters for the booth including the date(s) of the next round(s) to help the community identify it even from a distance and directional arrows at street corners pointing out way to the booth.

5.1.4 Booth functioning and administration of OPV :

- ❖ In summer months booths should begin to function early in the morning.
- ❖ Open only one vial of OPV and keep it outside the vaccine carrier.
- ❖ Ice pack **should not be removed** from the vaccine carrier to keep the OPV vial outside the vaccine carrier (Refer to section on cold chain).
- ❖ One member of the vaccination team at the booth shall receive the parents with their children and immunize all eligible children.
- ❖ Second team member shall mark every child on left little finger on the nail bed and adjoining skin with marker pen, after the child has been administered OPV drops.
- ❖ Third team member shall record information on tally sheet, immediately after each child has been immunised.
- ❖ Recording of unnecessary information such as name and address of children and parents or cross checking from lists, should be avoided at the booths
- ❖ After immunization, vaccinator must advise parents regarding continuation of routine immunization and remind them to bring all their children on the date of next NID/SNID round.
- ❖ Fourth team member shall help in crowd control by designating entry and exit points to the booth, ensuring one way flow and helping parents to make a queue. Each parent should stand in line only once.

- ❖ Booths should be located in shade. Vaccine vials and vaccine carrier should not be exposed to sunlight
- ❖ In the afternoon or earlier when the inflow of parents and children has decreased, two vaccinators should go to the community to mobilise children to the booth while two should stay back to immunise children coming to the booth.

5.1.5 Essential steps for increasing booth coverage:

The booth activity, to be successful in vaccinating maximum number of eligible children, needs to be supported by:

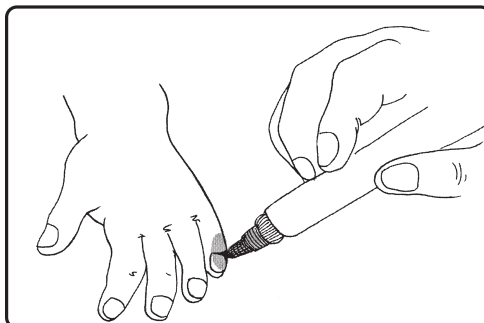
- ❖ Excellent Information, Education and Communication (IEC) over the mass media.
- ❖ Well planned local miking/drum beating on slow moving vehicles and from fixed sites starting 2 days prior to the booth day and continuing on the booth day.
- ❖ Interpersonal messages from the health workers during their planned home visits prior to the NID/SNID round.
- ❖ Community participation in the selection of the site, organization of the booth and vaccination.
- ❖ Increased mobilization of the community to the booths, at the local level by involving all sectors (Health, ICDS, Education, Panchayati raj institutions, local NGOs).
- ❖ Festive look at the booth with well-organized vaccination activity, pleasant atmosphere, and short queues.
- ❖ Launching of booth activity by local influencers or community leaders.

In the vast majority of cases where children were not brought for immunization, it was simply because their parents did not know they had to bring them

5.2 Marking of children :

All children vaccinated at booths transit sites or h-t-h visit in NIDs/SNIDs should be marked with indelible ink marker pen on the left little finger.

- ❖ The mark should be large and cover the entire nail and adjoining skin.
- ❖ The mark should be allowed to dry for a few seconds to prevent it from being rubbed off by the child.
- ❖ Marker pen should be capped immediately and kept in horizontal position to prevent it from drying.



5.3 House to House Immunization activity :

The aim of the NIDs/SNIDs is to vaccinate all under 5 children. To ensure this teams must visit each household in the NID/SNID area. The duration of the house-to-house (h-t-h) search and immunization operation should be decided by the number of available vaccination teams in the area because teams have to be allotted rational/feasible work load. In principle, there should be 2 to 5 day h-t-h activity in areas depending upon the availability of sincere and committed teams.

5.3.1 Area allocation and workload of teams :

- ❖ Each team should be allocated clear-cut, well-demarcated areas clearly mentioning the starting and ending points, identifiable with landmarks; for each day of h-t-h activity.
- ❖ Each team should be given optimal workload in consultation with the vaccinators and supervisors working in the area taking into account the local geographical conditions and the time taken in travel and to revisit X houses. The number of houses to be covered each day should not be fixed by the district officials. However as a general guideline :
 - In rural areas 80 - 100 houses per team per day may be planned. This number may be changed in view of local situation to allow optimal time for travel and revisits to X houses.
 - In urban areas 110 - 125 houses per team per day may be planned.
- ❖ The number of houses per day may be less in sparse/scattered population. This number may vary from day to day depending upon the geographical situation of area planned to be covered by the team on a particular day.
- ❖ The no. of houses to be covered each day should be mentioned in the microplan.

5.3.2 Composition of teams :

- ❖ Teams of two persons each should go house-to-house from day 2 onwards, for immunizing children who did not turn up at the booths on day 1.
- ❖ Out of the two members in each team, one should be a local volunteer.
- ❖ At least one person in each team should be a female.
- ❖ In high risk areas one additional person from the local community, where team will be working, should accompany the team. This person should preferably be a female or someone with recognition and influence in the community. In areas where misinformation is an issue, the person should be a local religious leader/local doctor.
- ❖ While planning for rural areas, ensure the following in the micro plan :
 - All hamlets (tolas/ purwas) adjoining the village are documented and covered during the activity.
 - Brick kilns are covered by h-t-h team or special mobile teams.
 - Names of prominent local influencers like pradhans, panchayat members, local doctors, teachers, religious leaders, anganwadi workers etc. are incorporated.
- ❖ For urban areas ensure that :
 - All peri-urban areas, slums, pavement dwellers, construction sites and new settlements are covered in the micro plans.

- Households on upper floors are accounted for while estimating no. of houses to be covered by teams.
- The names of local resident welfare organizations, community leaders etc. are included in the microplans.

5.3.3 Activities of teams:

(a) Search and Immunization of children during house to house visits :

- ❖ During h-t-h activity, maps should be used to visit all houses systematically as per the micro plan. No house should be left unvisited.
- ❖ Vaccination teams must not sit at a convenient place to immunize from day 2 onwards but visit all houses in their designated area and actively search for all unimmunized children who did not turn up at the booths on day 1.
- ❖ House to house visits and revisits to 'X' marked houses should be undertaken at the time when children are most likely to be available at their homes.
- ❖ Vaccination teams should receive their vaccine and other logistic supplies and check them before starting the immunization activity. They must check all OPV vials before immunization and make sure that VVM has not reached the discard point.
- ❖ During house-to-house visits, teams should knock at the door and enter each house.
- ❖ Team should then greet the parents politely, introduce themselves, and explain the purpose of their visit.
- ❖ The next task is determining the correct number of children less than five years, children immunized at the booth and children left to be immunized. To determine correct information, the vaccinators have to go systematically and ask all the following questions in each house:
 1. How many families (households) are staying in the house? Number of families is to be determined by the number of 'chullahs' (kitchens).
 2. What is the number of children less than 5 years in each house hold?
 3. Are all children present in the house? Determine information household wise.
 4. How many children less than 5 years of age have been immunized at the booth? Examine the children immunized at the booth, for finger marking, if they are present at home.
 5. Are any children less than 5 years of age (who normally live with the family) away from home for reasons like:
 - Gone to school or fields or market place.
 - Playing outside the house.
 - Visiting friends /relatives within the village or in other villages / cities
 - Gone out with parents to their place of work .
 6. Any child less than 5 years of age, of relatives or friends, visiting the house hold? (They should also receive OPV drops).
 7. For determining correct number of less than 5 years old children, teams should physically examine children present in the house. Start with the youngest child and go on to the next elder and so on.
- ❖ All unimmunized children less than 5 years of age present at home should be administered OPV drops.

- ❖ One member of the team should immunize the children and mark every immunized child on left little finger with indelible ink marker pen , allowing the mark to dry for a few seconds.
- ❖ Vaccinators should advise parents regarding continuing routine immunization and inform them about date of next NID/SNID round and nearby booth locations.
- ❖ The second member of the team should mark the tally sheet after every child is immunized and mark every visited house as P/date or X/date with chalk or geru.
- ❖ Before moving to the next house, team should thank the parents/caretakers for their cooperation and be doubly sure that all target children especially those less than two years of age have been immunized in the house, since polio affects children less than two years of age more commonly.
- ❖ Details of unimmunized under five children of the visited house should be entered in the X Tally sheet.

Every child less than 5 years of age in each household should receive OPV dose during each NID/SNID round

(b) Immunizing children outside houses :

During h-t-h visits, teams as well as the supervisors should be on the lookout for unimmunized children on the street , in the play grounds, fields and creches located in houses by examining them for finger markings and immunize all unimmunized children.

(c) Marking of houses by vaccination teams :

All visited houses should be marked with white/coloured chalks or geru as :

P/date:

- ❖ All children less than 5 years of age staying in the house **have received OPV dose** in this round. This includes children visiting the house when the supplementary immunization activity is on.
- ❖ No child less than 5 years in the house.
- ❖ All children in the house are over 5 years of age.

X/date:

- ❖ All or some children less than 5 years of age **have not received OPV dose** for reasons like:
 - Children not at home for the following reasons
 - ◆ Away to fields, school or market places
 - ◆ Visiting friends or relatives
 - ◆ Accompanying parents to place of work
 - Refusal
- ❖ Locked house - **even if the family is not expected to return for a period of one to two years.**

A list of X /Date houses should be made on the X tally sheet and submitted to supervisor at the end of each day by each team. Teams should also indicate the number of the house visited and put an arrow in the direction where they are moving.

| EXAMPLES OF HOUSE MARKING | | | |
|----------------------------------|--------------------|--------------------|--------------------|
| $\frac{P-1}{Date}$ | $\frac{P-2}{Date}$ | $\frac{X-3}{Date}$ | $\frac{P-4}{Date}$ |

(d) Revisit to X houses:

All X marked houses generated by vaccination teams during the day, irrespective of cause should be revisited by teams during afternoon/evening to immunize children in these houses. Teams should make these revisits at a time when the children are expected to be available in the house. The biphasic nature of the activity should be essentially planned to ensure immunization of such children who were out of the house at the time of first visit.

- **In areas where acceptance of vaccine is an issue, revisits to X houses should be made along with the local influencers/community leaders who would be able to motivate the family better for accepting the drops.**
- **Flexible timings and flexible days of activity will allow greater reach of OPV.**

5.4 Planning and immunizing children in Transit :

Large number of children are in transit during NIDs/SNIDs. It is essential to cover all these children through Transit teams.

5.4.1 General instructions :

- ❖ Transit teams should be present at major railway stations, bus terminuses, ferry crossings, highways and airports.
- ❖ Transit teams should also be deployed at prominent road crossings in cities and major tourist attraction points.
- ❖ The number of such teams and number of shifts should be determined by the quantum and peak timings of traffic at these points.
- ❖ Teams must be deployed in multiple shifts and round the clock at Railway stations/Bus stops if so required to cover the arrival and departure of all trains and buses.
- ❖ It should be ensured that **all these teams are pro-active** and are actively looking for target children and not passively sitting at one place and waiting for children.

- ❖ Transit teams **should be deployed for all the days of the NID/SNID activities**, i.e., during the booth-day as well as the house-to-house day operations.
- ❖ Every vaccinator deployed at transit points **must constantly move around and actively look for children**, independently immunizing and finger marking them. Vaccinators must **never sit at one place** and wait for children to come to them.
- ❖ Vaccinators shall walk through crowded areas to approach children and their parents.
- ❖ Vaccinators must identify parents / caretakers with target age children at transit points
 - Greet the parents politely so that they feel comfortable.
 - Ask the parents if their child has been immunized during the current round of immunization activities.
 - Check finger marking on all children to find out if they have been vaccinated or not.
 - **Finger marking MUST be verified** on each child that parent says has been vaccinated. If finger-marks are not visible, it must be assumed that the child has not been vaccinated. In this situation, vaccinators must make every effort to vaccinate the child.
 - If child has not been vaccinated in the current round, administer two drops of OPV to all such eligible children.
 - Vaccinators should obtain consent from parents before vaccinating their children. If a child is alone, vaccinators should try to locate child's parents or caretakers to ask for permission before vaccinating the child.
 - If parents ask any questions, respond politely to their queries.
 - After immunization, thank the family for their cooperation and remind them to immunize their children on the date of next NID/SNID round.
- ❖ If parents refuse vaccination, vaccinators should politely try to convince them to accept OPV. **If parents are not convinced, vaccinators should not get into lengthy arguments with them or force them to accept OPV.** Instead, vaccinators should start looking for other unimmunized children at the transit point.
- ❖ Recording of unnecessary information such as name and address of children and parents should not be done at the transit points.

5.4.2 Transit Teams at Railway Stations :

- ❖ At railway stations vaccinators should be stationed at all possible entry and exit points. Additional vaccinators should cover railway platforms.
- ❖ Before the arrival of trains, all vaccinators must approach parents entering the railway station and immunize children accompanying them. Vaccinators covering the railway platforms should move in between the crowds waiting to board the train and vaccinate children.
- ❖ Upon arrival of trains, all vaccinators must reposition themselves at entry/ exit points. All vaccinators at these points shall check and vaccinate children exiting from the station. Vaccinators must take help of personnel

from railways for identifying and directing parents with children towards the vaccination teams upon arrival of trains.

5.4.3 Transit Teams at Bus Terminals :

- ❖ At bus terminals vaccinators should be stationed at all possible entry and exit points. Additional vaccinators would cover areas where passengers are waiting to board buses.
- ❖ Vaccinators at entry/exit points must approach parents entering or exiting the terminal and immunize children accompanying them. Vaccinators covering the areas where passengers are waiting should move between the crowds and vaccinate children.
- ❖ Upon arrival of a bus, vaccinators working at these sites must check and vaccinate all eligible children getting off the bus.
- ❖ After passengers alight, vaccinators will board the bus and check and immunize children travelling inside the bus.

5.4.4 Transit teams at important road crossings, roadside bus stands, toll booths on highways, important river bridges etc.

- ❖ Vaccinators should position themselves to cover all sides of the road.
- ❖ Vaccinators should stop buses or other modes of transport that are plying such as jeeps, tempos, auto-rickshaws, cycle rickshaws, bicycles, tractor trolleys, carts (buggi). To do this they may take help of local traffic police for stopping the vehicles carrying children.
- ❖ Upon arrival of a bus/other vehicles, vaccinators shall check and vaccinate children getting off the vehicles.
- ❖ After passengers alight, vaccinators must inform the driver and conductors of vehicle and then get into vehicles to immunize children sitting inside.

5.4.5 Vaccination in moving trains:

Trains passing through endemic areas should have vaccination teams of Railway department with pre identified embarkation and disembarkation points for immunizing children in moving trains. These teams should check children inside the train and immunize all children who have not been immunized earlier by asking parents and examining finger markings.

Vaccinators must be proactive in seeking and immunizing children at Transit points, Melas and other Congregation sites

5.5 Micro Planning for High Risk Areas and Underserved Population :

Evaluation studies conducted in India and in many other countries have shown that the same population groups are often missed by the routine programme as well as by supplemental immunization campaigns. All these groups must be identified and such areas listed in the micro plans. **These areas should be considered as high risk and the population as underserved.**

5.5.1 Indicators for High-risk areas and underserved population include the following:

- ❖ A wild poliovirus confirmed case has occurred in the recent past (year 2005 onwards).
- ❖ Problems in surveillance like non-reporting/ late reporting of AFP cases, non-collection/ late collection of stool specimens.
- ❖ Large immunity gap (large proportion of children who have received less than 4 doses of OPV) as determined by proportion of less than 5 years old Non Polio AFP cases having less than 4 doses.
- ❖ Low routine immunization coverage.
- ❖ Urban slums or peri urban areas not recognized by district authorities.
- ❖ Remote, sparse and difficult to reach population groups like nomadic tribes, boat people, isolated families living along riverbanks for farming, river islands etc.
- ❖ Mobile population and tribes
- ❖ People with working hours that do not coincide with the visit of teams (for example children going to the fields along with their parents during harvesting and sowing seasons are simply missed because teams do not reach either before they leave or after they come back from the fields).
- ❖ Children living at construction sites, brick kilns
- ❖ Travellers, who may be on the road or in the train when the campaign takes place.
- ❖ People living in houses outside recognized settlements (the “no man’s land”).
- ❖ People that have lost their faith in the health programme, because of low quality of services provided, lack of explanation, and/or rude behaviour of vaccinators or supervisors in the past.
- ❖ People of specific socio economic status, which require ‘special’ efforts to reach. Persons with high socio economic status may disagree with supplemental immunization, because their child has already received routine doses. People of low socio economic status may distrust anything offered for free and request other services.
- ❖ Misinformed groups, who may refuse immunization because of wrong beliefs about side effects of OPV (impotence etc.) based on rumours. They do not oppose immunization because of religious reasons, but because of lack of proper information through the proper channels.

5.5.2 Special efforts for high risk areas and underserved populations:

The States and districts will **need to take special measures** to ensure that all children are immunized in these high-risk pockets. The special measures for high-risk areas include the following (**these are in addition to what is already being done for other areas**):

- ❖ Intensive efforts for social mobilization and IEC need to be undertaken in these areas, such as:
- ❖ Intensive miking, house-to-house visits by health workers to involve community leaders, panchayat members particularly the women members, religious leaders and other local influencers like medical practitioners,

traditional birth attendants, local moneylenders, grocery shop owners, popular teachers, prominent youth etc to provide proactive support.

- ❖ Local community members/influencers must accompany vaccination teams during house-to-house visits in such areas, especially during revisit to X houses.
- ❖ Female community members residing in the area should be a part of vaccination teams. This will improve access to all children in the area.
- ❖ Team composition, workload and timings of team visits.
- ❖ Deployment of reliable trained and motivated manpower in such areas - best workers for worst areas.
- ❖ Workload of house-to-house vaccination teams should be rationalized to give a feasible workload to each team.
- ❖ The vaccination teams should undertake house-to-house visits when parents and children are most likely to be available at their homes. This may require changing hours of operational activities to early mornings or late evenings.
- ❖ **More intense supervision in the area with supervisors being allotted less number of house-to-house vaccination teams.**
- ❖ Increased supervision in these areas by state and district officials who should make frequent visits both during planning and implementation phase.
- ❖ Designate a person in each district to be responsible for these underserved population groups/areas.
- ❖ Intensive monitoring of such areas by best independent monitors to get accurate feedback.
- ❖ The number of booths in these areas must be more than in other areas so that parents can take their children to a nearby booth.

5.5.3 Immunizing children of misinformed groups :

Vaccination teams working in these areas should be specifically selected and specially trained to search for all unimmunized children, in each household, convince their parents and then carry out immunization activities.

- ❖ Each house-to-house immunization team in such areas must have at least one female member appropriate to the community where they are working.
- ❖ Teams in such areas should be assigned no more than 80 - 100 houses per day. This would allow the teams to spend more time in each house.
- ❖ Local community members/influencers must accompany vaccination teams in such areas to convince reluctant community.
- ❖ Teams should also carry appeals from community/religious leaders to convince reluctant parents.
- ❖ During house-to-house immunization in these areas the female vaccinators in the team should take the lead in seeking permission from parents/caretakers before entering the house.
- ❖ After introducing themselves and explaining the purpose of their visit vaccinators should determine the number of households in each house (as defined by the number of kitchens in the house) and then determine the number of eligible children in each household by asking all relevant questions.
- ❖ In order to accurately determine the number of children in each household team members should be vigilant for signs that indicate young children are

living in the house like children's clothes, toys, slippers, shoes etc.

- ❖ Additionally vaccinators should also cross verify the number of children living in the house and for any new births from neighbours, local influencers accompanying the teams, children playing in the street etc. Teams must check finger marking of each child and immunize all those children who are unmarked.
- ❖ If parents raise any queries vaccinators must respond in a respectful and courteous manner to clarify their doubts or misgivings.
- ❖ Teams should also seek help of local influencers to convince parents to accept OPV.

5.6 Immunizing children at Brick kilns, Construction sites :

Brick kilns, construction sites may be covered by either house-to-house immunization teams or mobile teams specifically constituted for this purpose.

- ❖ Vaccination teams must be specially trained to carry out immunization in these specific situations.
- ❖ Owners of brick kilns/construction sites must be informed well in advance about the date and purpose of visit by vaccination team by the district/block officials.
- ❖ The local clerk/contractor should be contacted in advance and a list of the families (along with under five children) working at the kiln/sites should be prepared.
- ❖ The vaccination team must carry this list during their visits.
- ❖ Vaccination teams must visit the homes of the workers at these sites and also surrounding brick fields (Pather/Pasar) where the families are making bricks. These may be situated at a distance of about 1-2 kilometres from the brick kiln.
- ❖ The teams should immunize all eligible children at these sites and should counter check from the list to ensure that all families are covered and all children under 5 receive OPV.
- ❖ Since families frequently migrate to these sites, brick kilns and construction sites should be visited twice during each round to ensure that all new arrivals have also been immunized.

5.6.1 Mobile teams :

- ❖ These are teams used to reach remote, difficult to reach sparsely populated areas like brick kilns, nomadic populations, construction sites etc.
- ❖ Each mobile team of two must have mobility support.
- ❖ Mobile teams carry out house to house immunization from day 1.

5.7 Vaccinating children at Melas and other Congregation sites :

Coverage of children in major melas and religious congregations should be included in the microplan. Vaccinators should be posted at :

- ❖ All entry and exit points must check and immunize children entering or leaving the congregation site.
- ❖ Additional vaccinators must move through crowds on congregation sites

and immunize children in the crowd. They must move continually and not stay at one place.

5.8 Micro planning for urban areas:

Planning for urban areas is crucial for successful implementation of NIDs/SNIDs. Some of the commonly observed deficiencies in urban areas are :

- ❖ Lack of adequate health infrastructure and manpower
- ❖ Large slums (unauthorized)
- ❖ Periurban areas with new settlements and some areas/colonies not recognized by municipal health authorities
- ❖ Multiple construction sites

For planning and implementation purposes, urban areas should be divided into smaller planning units based on municipal wards or assemblies and if this is not possible then by roads or prominent landmarks. Each such unit should be put under the charge of a medical officer or nodal officer. The officer should be responsible for :

- ❖ Development of microplans for booth and house to house immunization activities.
 - Manpower deployment in the area by arranging additional manpower from non health departments like social welfare, education and NGOs or volunteers.
 - Planning for vaccine distribution.
 - Developing a plan for IEC activities like :
 - ◆ Miking from fixed sites and slow moving vehicles like cycle rickshaws
 - ◆ Delivery of messages on the programme through the cable TV, cinema slides and telephone
 - ◆ Display of banners, posters, vertical boards, hoardings in the area. A list of prominent sites for display of these should be developed.
 - Meeting with community and religious leaders of the area
- ❖ Training of vaccinators and supervisors
- ❖ Inter-sectoral coordination with other agencies
- ❖ Supervision of immunization activities
- ❖ Daily feed back from supervisors and monitors and Immediate corrective actions during the round
- ❖ Compilation of daily reports and onward transmission to identified officer/official.

Involvement of local municipal bodies and their staff is essential in urban areas. Municipal staff is familiar with the layout of the urban areas and their inputs are vital for planning and supervision of booths and house-to-house activities.

Coordination with education department, social welfare, civil defence, other local NGOs, resident welfare associations and community leaders is vital for meeting shortage of vaccinators, transport and also for social mobilization.

Maps must be used while planning for urban areas. If maps are not available with municipal bodies vaccinators and supervisors should be sent to the area before the round in order to become familiar with the area and develop maps.

6. OTHER KEY COMPONENTS OF PLANNING AND IMPLEMENTATION

Besides planning and implementation of activity at booths, house-to-house, transit site etc. other key components which require planning and implementation are as under :

- ❖ Supervision
- ❖ Mapping of areas
- ❖ Orientation training of vaccinators and supervisors
- ❖ Vaccine, cold chain maintenance, other logistics and transportation
- ❖ IEC/Social Mobilization
- ❖ Recording and reporting
- ❖ Review of micro plans and data analysis for planning interventions
- ❖ Use of data for planning actions

6.1 Supervision :

High quality supervision is vital to the success of the programme. Supervision should not merely be inspection for fault-finding. Supervisors should be supportive and should be able to :

- ❖ Identify problems and help to solve them.
- ❖ Support, encourage and motivate vaccinators in carrying out high quality vaccination activities completely.

Supervisors must carry out the following activities: -

- ❖ Assist the BMO/SMO in reviewing and revising micro plans for booth and house-to-house activities before the NID/SNID round. This includes:
 - Selection of appropriate booth locations
 - Selection of vaccinators appropriate to the area and the community.
 - Assignment of the areas to house-to-house vaccination teams in terms of
 - ◆ Well defined boundaries
 - ◆ Clearly identified start and end points with landmarks
 - ◆ Allocation of rational workload
 - ◆ Developing a reasonable daily itinerary for house to house visits by the teams.
 - Developing maps for teams and supervisors
- ❖ Help vaccinators in identifying local influencers and defining their roles.
 - The names of the local influencers should also be incorporated in the micro plan.
- ❖ Visit vaccination teams working under him/her during booth and house to house immunization activities to :
 - Identify issues like last minute absenteeism of vaccinators, shortage of vaccine and logistics and solve them.
 - Ensure that vaccination teams are working as per their microplan and that :
 - ◆ All areas and houses are visited, including isolated communities, mountainous areas, and apartment dwellers on top floors

- ◆ All children <5 years receive two drops of OPV
- ◆ All teams read VVM to ensure that delivered OPV is potent
- ◆ Tally sheets are marked immediately after each home visit
- ◆ Correct marking of houses and children
- ◆ Vaccination teams revisit X marked houses
- Ensure that vaccine and logistics are distributed to vaccination teams as per plan.
- Randomly visit a sample of the 'P' marked houses to detect unimmunized children.
- Visit 'X' marked houses of reluctant parents to convince them about the need to immunize their children .
- For teams not performing well, conduct on the spot training of untrained vaccinators and reorientation of vaccinators.
- Assist medical officer in replacing poorly performing vaccinators
- Collect, compile and analyse data from vaccination teams.
- ❖ Attend evening meeting and provide feedback to Medical Officer.
- ❖ Logistics and supplies are prepared for the next days work

The supervisors should be familiar with the area, prepare a supervisors' maps with assignment of teams on map, and develop a plan for supervising teams in a systematic and planned manner. Each supervisor should be independently mobile. No matter how well supervisors are trained, if they are not independently mobile, they cannot supervise properly. They should use the supervisors' formats to supervise teams in the field.

Each supervisor should visit the booths at least thrice on the booth day and visit each team at least twice during the h-t-h days. All mobile teams and transit teams should also be supervised.

Supervisors must be trained on their role with the help of the training instruction given in the annexure.

If a monitor or supervisor, during random crosschecking of areas, already visited by vaccination team, detects 3 or more than 3 false 'Ps', then the vaccination team must revisit all houses in that area.

- **Supervisors must pay attention to high-risk areas and go where teams do not like to go**
 - **Each Supervisor must be independently mobile**

6.2 Mapping :

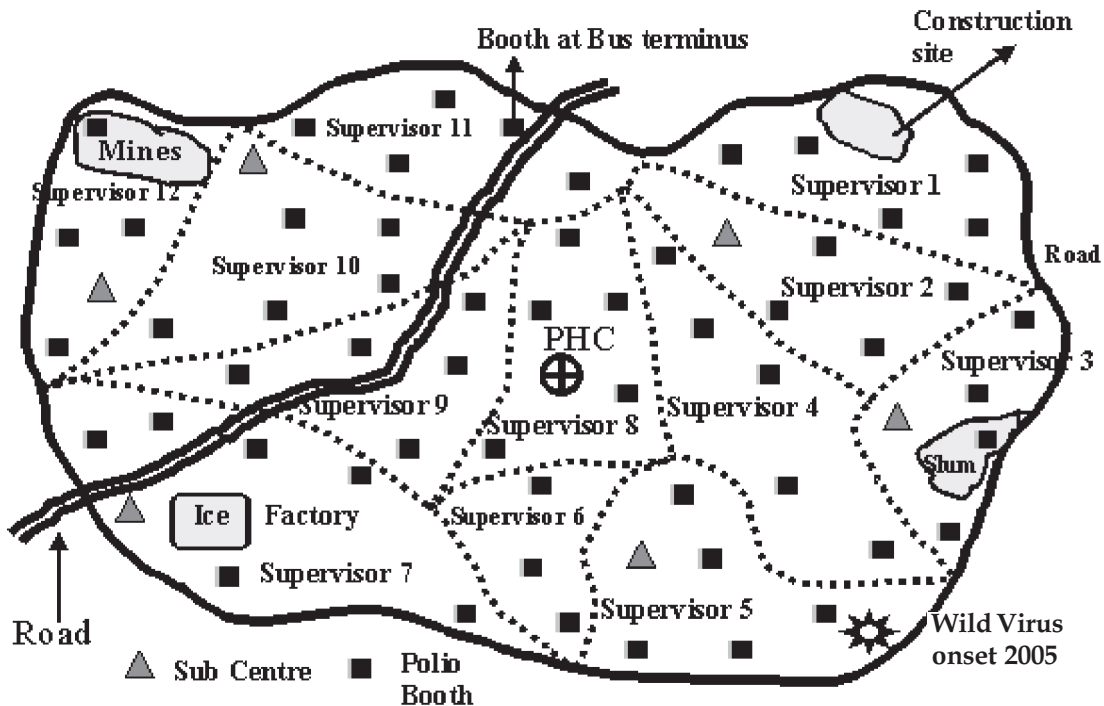
Maps are useful for planning and ensuring completeness of activities.

6.2.1 Planning unit Maps :

Maps should be developed at each block/ PHC/ Urban area and should indicate:

- ❖ Supervisors' areas with demarcation
- ❖ Vaccine distribution points
- ❖ High risk and difficult to reach areas
- ❖ Areas from where wild virus or compatible cases have been detected
- ❖ Population likely to be missed
- ❖ Ice factories
- ❖ Major landmarks and roads

Sample Map of planning unit-PHC/urban area

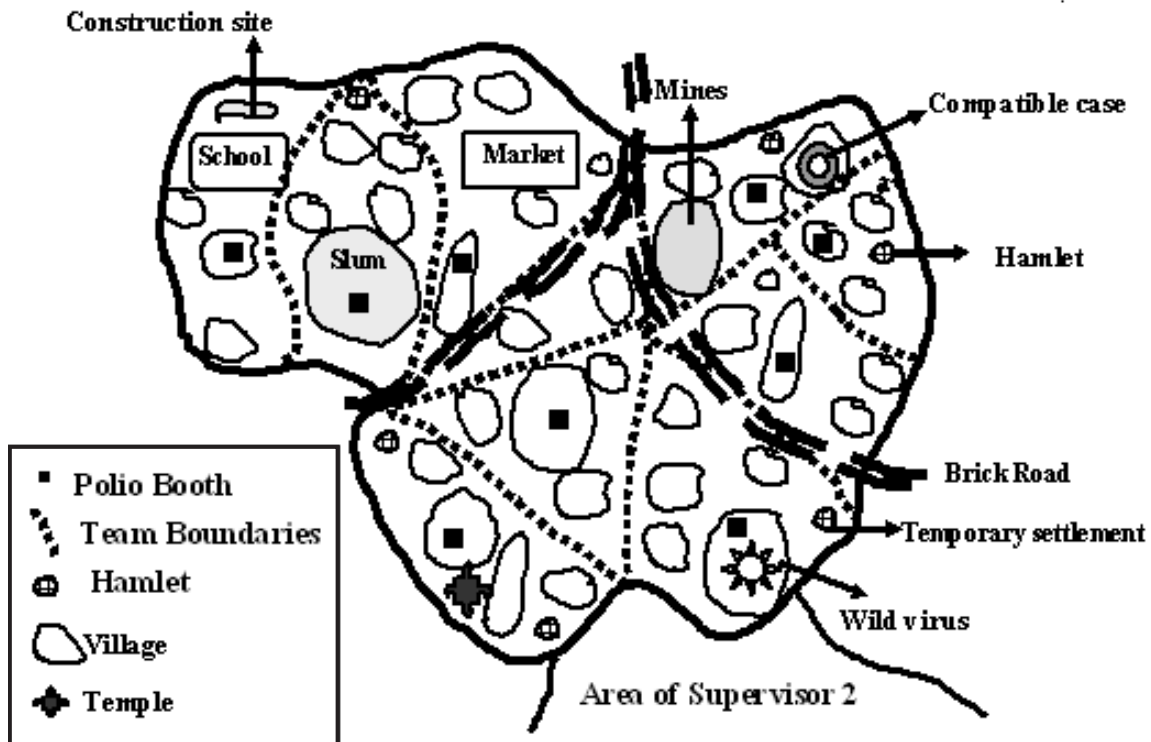


6.2.2 Supervisor Maps :

Every supervisor should also have a map that indicates :

- ❖ Team areas with demarcation and day wise work plan
- ❖ Location of Booths
- ❖ Villages /urban wards / mohallas/ urban slums / hamlets
- ❖ High risk areas
- ❖ Areas from where wild virus or compatible cases have been detected
- ❖ Population likely to be missed
- ❖ Major landmarks and roads

Sample Map of a Supervisor



A team that is not equipped with a map of the area and an itinerary for covering the area will certainly miss children

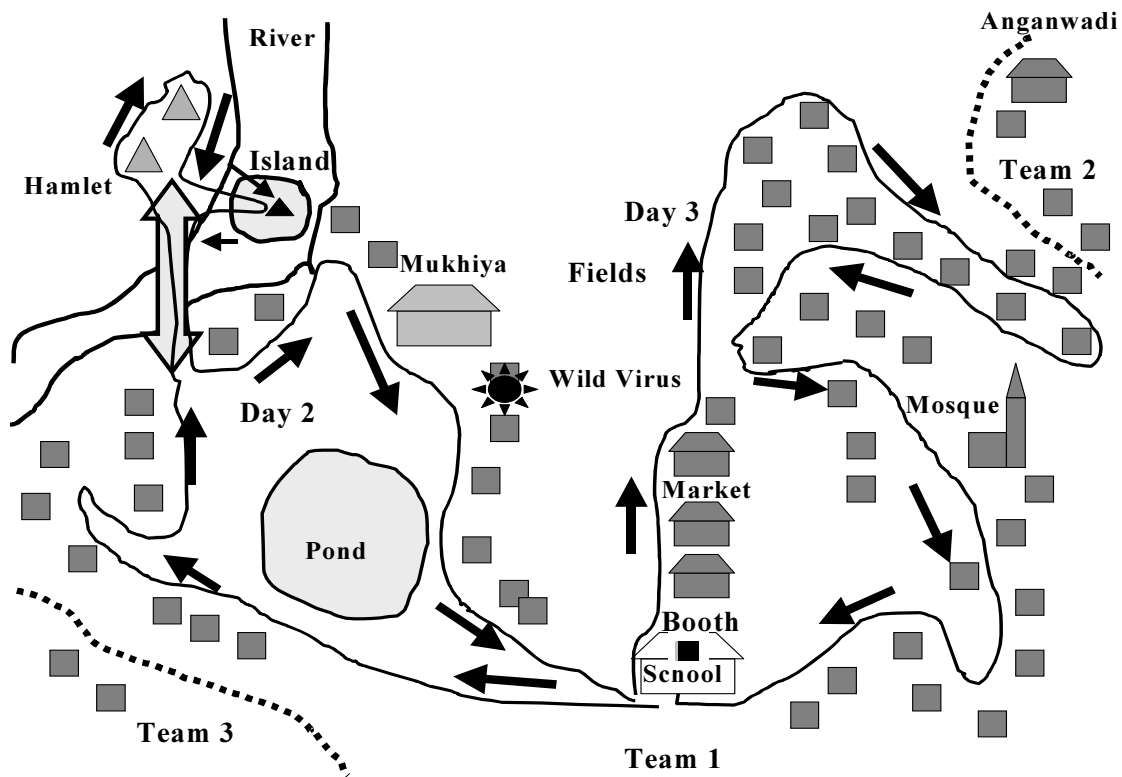
6.2.3 Team Maps :

Each team must have a map and itinerary for the area it will cover. It has been shown repeatedly that even local vaccinators will miss children if they do not have a map and itinerary to guide them. In addition, maps are helpful for teams to mark and revisit X houses.

For each team, find or draw a map that indicates:

- ❖ Each settlement's location
- ❖ Streets and landmarks within each settlement
- ❖ Location of booth
- ❖ Houses and hamlets lying outside of the main roads
- ❖ Major landmarks (e.g., rivers, bridges, health centres, schools, markets, nurseries, train/bus station, police check points, etc.)
- ❖ Roads and tracks
- ❖ The precise limits of the catchment area of the team (the border of their working area), showing without ambiguity where another team takes over. Indicating a street, as boundary between teams is insufficient without clarifying which team covers which side of the street. Lines separating territories of villages often overlook houses in between the main settlements.

Sample Map of a Team

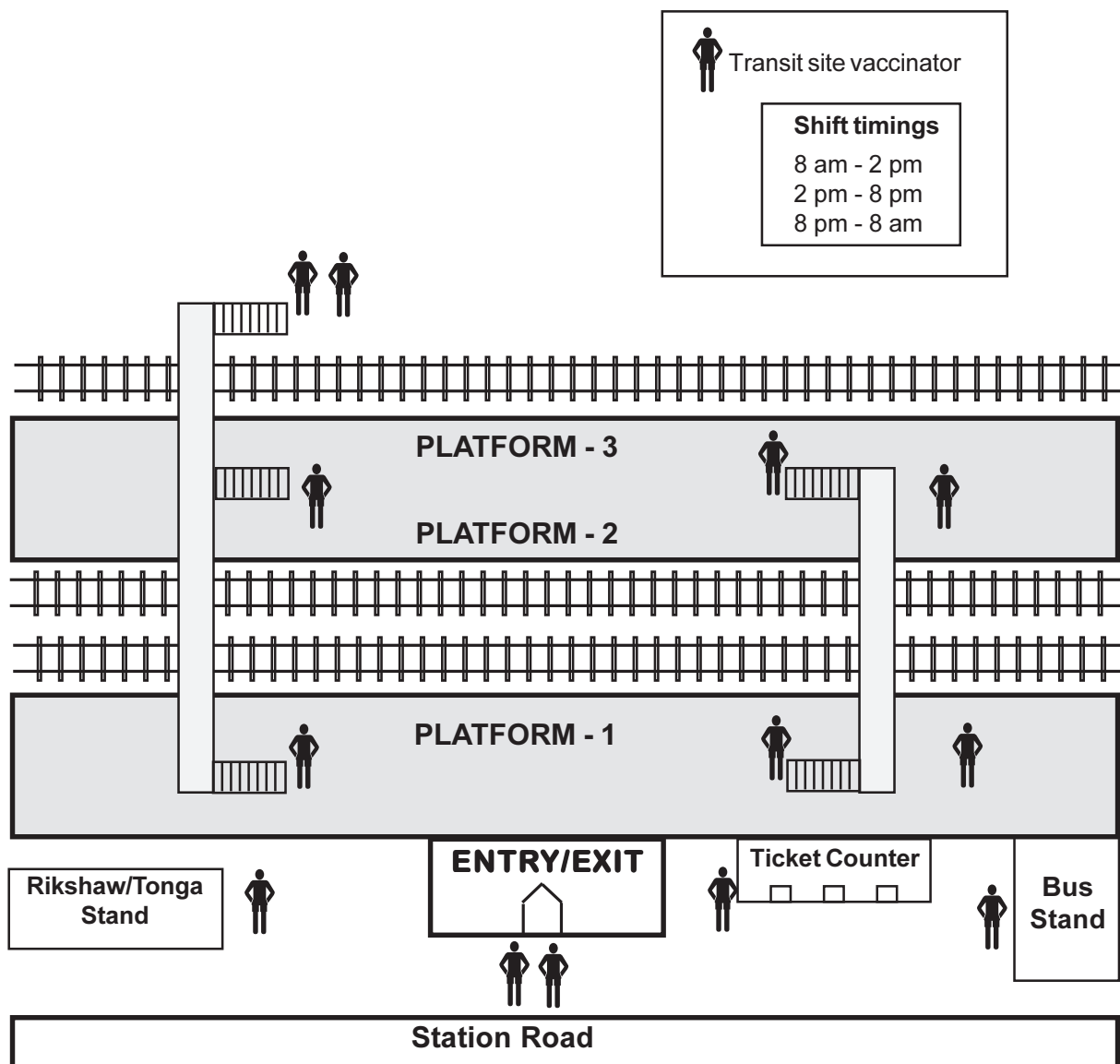


6.2.4 Transit Site Maps :

Maps for transit and congregation sites are extremely useful for planning deployment of vaccinators at various locations on transit and congregation sites. Transit site maps should indicate the following :

- ❖ Deployment of vaccinators at different locations on transit/congregation sites.:
 - All entry and exit points
 - Other important locations on these sites for placement of vaccinators
- ❖ Number & timings of shifts for deployment of vaccinators

Sample Map of a Transit Site



6.3 Orientation Training of Supervisors and Vaccinators :

6.3.1 Orientation of Vaccinators :

The District training team /Block Medical Officers/Urban Health Officials must brief the vaccinators a week or two before the NID/SNID. Surveillance Medical Officers of NPSP shall orient supervisors and vaccinators in high-risk areas/blocks. The briefing will be organised in batches of 40 - 50 vaccinators per session and will last for about half a day. The supervisors along with their vaccinators shall attend the sessions. The trainers should refer to the training instructions for details on how to conduct orientation (Annexure I).

The orientation will cover the operational as well as the interpersonal communication aspects of the NIDs/SNIDs. The instruction sheet for vaccinators, tally sheets, infokit on frequently asked questions should be distributed and discussed during this orientation. The training session has to be interactive and participatory with particular focus on newly inducted vaccinators. Demonstration of VVM stages, finger marking tally sheet and house markings followed by exercises for ensuring all operational skills as also Role Plays on IPC and FAQs should form an essential component of the all vaccinators' training sessions

6.3.2 Orientation of Supervisors :

The District training team /Block Medical Officers/Urban Health Officials/ Surveillance Medical Officers of NPSP should undertake a half-day orientation of the supervisors. During orientation, crucial role of the supervisors in making NIDs/SNIDs successful should be essentially discussed and emphasized. The instruction sheet for supervisors should be distributed to the supervisors and discussed during orientation. The tally sheets, 'P' sweep tally sheet, supervisors' daily reporting format should also be distributed and exercises conducted on these during the orientation. The trainers should also refer to the training instructions on how to conduct orientation (Annexure I).

6.4 Vaccines, Cold Chain, other Logistics and Transport :

6.4.1 Vaccines :

Requirement of vaccine should be calculated using a wastage multiplication factor of 1.27

Total OPV doses required in each round = Estimated children < 5 Years or highest no. of children immunised in previous NID/SNID round x 1.27

OPV vials required in each round = $\frac{\text{Total OPV doses in each round}}{20}$

(Rounded off to the next higher whole figure)

The block/urban area micro plan should take into account the number of cold boxes/ ILRs/ deep freezers that are available for storing and transporting the required OPV vials as well as freezing and transporting ice packs. Power supply to maintain an effective cold chain should be ensured.

Micro plans should ensure not only the availability of adequate quantities of vaccine, vaccine carriers and icepacks/ice but also the vaccine distribution points and the distribution plan for these essential logistics.

Planning for cold chain should include ensuring availability of sufficient well-frozen ice packs for all teams on booth day and also on all house-to-house days. **This means that there should be 3 cycles of ice packs available with the district.**

The micro plan should also include identification of freezing units (ice factories) to ensure availability of sufficient ice packs for each day.

Each booth should have a vaccine carrier with well-frozen ice packs. Similarly each house- to-house team and each supervisor should have a vaccine carrier with well-frozen ice packs/ice. Supervisors and vaccinators should know the source of vaccine, ice and frozen icepacks.

The number of vials supplied to each booth or house-to-house vaccination team should be based on the expected number of children that are likely to be vaccinated each day. In case more children attend the booth, supervisors should provide the replenishment.

6.4.2 Vaccine handling guidelines :

General instructions for vaccine handling by vaccinators:

- ❖ Protect the carrier and OPV vials from sunlight.
- ❖ Open only one vial at a time and keep it outside the carrier.
- ❖ Do not open and close the lid of the carrier repeatedly.
- ❖ Open the lid of the carrier only after finishing the previous vial to take out another vial.
- ❖ Ice packs should not be removed from the vaccine carrier to keep the vials outside the vaccine carrier.
- ❖ Look at the VVM before giving drops to each child and only use vaccine where VVM square is lighter than circle (i.e. has not reached discard point).
- ❖ The labels of the OPV vials should be protected to ensure VVM can be interpreted. Placing them in plastic bags can do this.
- ❖ Nozzle of OPV vial should be capped immediately after use.
- ❖ A new plastic cap should be used each time a new vial is opened.
- ❖ Partially used OPV vials should be returned to the block/urban area and stored in proper cold chain conditions so that they can be reused on subsequent days subject to the condition that their VVM has not reached discard point.

6.4.3 Vaccine Vial Monitor (VVM):

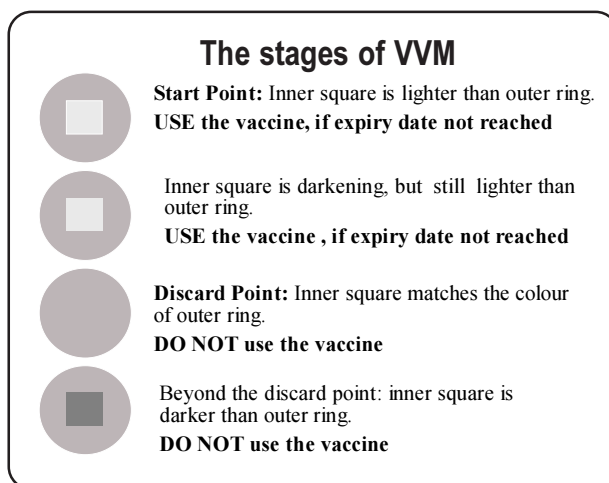
Oral polio vaccine is the most heat sensitive of all EPI vaccines. Storage and transport have to comply with good cold chain practices. However, cumulative heat exposure can be monitored with the help of the Vaccine Vial Monitor (VVM), which is found on all OPV vials supplied for use.

VVM is a heat sensitive square within a circle that changes colour under the combined influence of heat and time. If after exposure to heat for a certain amount of time, the square reaches the same colour as the circle, or becomes darker than the circle, the vial must be discarded.

At lower temperatures the loss of potency is considerably slowed down and the time taken for the VVM to reach the discard point increases substantially. The length of time to reach discard point depends on ambient temperatures and *the quality of the cold chain until that point*. OPV, supplied by WHO accredited manufacturers, retains satisfactory potency for at least 48 hours at an ambient temperature of 37°C. At 25°C continuous ambient temperature the VVM will reach the discard point only after 7 days.

The VVM allows the user to see at any time if *OPV can still be used in spite of possible cold chain interruptions* thus guiding health staff and management to take corrective measures.

All OPV vials used in India have VVM on them. **The loss of potency of vaccine and the discard point of VVM correlate exactly. As long as the discard point has not reached, the OPV is fully potent and should be used.**



OPV supplied in India is subjected to pre-release testing. OPV used in India is purchased from suppliers who meet WHO pre-qualification standards.

VVM helps to manage the OPV better for the following reasons:

- ❖ Helps to decide which vials to use first in nearby areas on the basis of change of colour of VVM.
- ❖ Helps to decide whether partially used/ unused vials returned from field can be used on subsequent days or not.
- ❖ Helps to decide whether OPV vials that have remained outside of cold chain in the field can be used or not.

Unused and partially used vials returned from the field should be reused on subsequent days subject to the condition that their VVM has not reached discard point

6.4.4 Use of Monovalent OPV :

Trivalent OPV (tOPV) which is effective against all 3 polio virus serotypes, has been in use for Polio Eradication activities since the inception of the programme not only in India but also globally.

In September 2004, WHO's Advisory Committee on Polio Eradication (ACPE) reviewed options for maximizing immunity for each SIA contact and recommended that in addition to improving the quality of SIAs in areas with persistent polio virus type1 transmission, the use of mOPV1 should be started to complement the existing polio eradication efforts. This recommendation was based on the superior polio virus type 1 immunogenicity of mOPV1 as compared to tOPV in tropical conditions. Seroconversion with one dose of mOPV1 was observed to be 81% as compared to 42 % with one dose of tOPV. This recommendation led to licensing and manufacture of mOPV1 in record time in the country.

In view of the total elimination of type 2 virus globally since October 1999 and a very significant decline and extreme focalization of type 3 virus transmission in India (to only one pocket in western UP), but predominance of persisting type1 polio virus transmission in some areas of India , the use of mOPV1 was started for the first time in April 2005, in high risk districts of western UP, Bihar and areas of Mumbai/ Thane. The use of mOPV1 has since been continued in high risk areas of the country with continuing type1 virus transmission , in subsequent SIAs.

After the confirmation of a wild polio virus type 3 case in Moradabad district, a special pulse polio round using monovalent OPV3 (mOPV3) was conducted in 10 districts of western U.P including Moradabad, from 25th December 2005. This was the first time ever that mOPV3 was used anywhere in the world.

The decision on whether to use monovalent or trivalent vaccine during SIA in a particular area is based on the epidemiological data. This decision is taken by the Central Operations Group.

6.4.5 Other logistic materials :

Other material required by vaccination teams are :

- ❖ At least 10 vaccinators tally sheets per team.
- ❖ Supervisors' P sweep tally sheet.
- ❖ One vial opener per h-t-h team (if glass vial supplied).
- ❖ 10 to 20 chalk pieces per team or geru (during house-to-house days).
- ❖ 2 arm bands/ identity cards per team.
- ❖ Indelible marker pens 1 for each booth (day 1) and 1 for each team (day 2 onwards).

6.4.6 Transport :

- ❖ Microplans should include the number of vehicles (four/three/two wheelers), boats, animals etc. needed for transport of vaccine and supplies, vaccination teams, mobile teams and supervision.

- ❖ Efforts should be made to mobilize as many vehicles as possible from Health and other Govt. departments. The remaining additional vehicles may be hired.
- ❖ Every vehicle used must have a route chart clearly indicating the purpose for which the vehicle will be used, places to be visited along with the route and the approximate time of the visit.
- ❖ All efforts should be made to use existing vehicles.
- ❖ Locally appropriate independent transport/mobility arrangement for each and every supervisor is a must and should be a part of the micro plan.

All vehicles must have a route chart

6.5 Recording and Reporting :

- ❖ A tally sheet (Form 8 A) should be used for recording number of children immunized and houses visited. No other system of recording should be used. Templates for tally sheets are given as forms 8A to 8D. Areas that have conducted mop-ups and have experience of using different tally sheets on booth (Form 8C) and house to house days (Form 8D) should continue to use the same tally sheets.
- ❖ On h-t-h days record the number of houses visited and the number of children immunized in each house. Details of X houses should be recorded on the X tally sheets by each team every day (Form 8 B).
- ❖ On each day, record the details of the vaccine received and vaccine returned (used and unused) on the tally sheet.
- ❖ There should be no registration or enumeration of children.
- ❖ At the end of each day, each supervisor should go through the tally sheets of all his/her teams, compile the information and submit a consolidated report using the reporting form for supervisors (Form 9A).
- ❖ At the end of each day, each block/urban area should send to the District Immunization Officer (DIO) a report of children immunized and houses visited using form 9 B.
- ❖ The district should compile the report on form 9 C and send a consolidated district summary report to the state on form 10.
- ❖ The SEPIO shall consolidate the state report on form 11 and FAX it to Deputy Commissioner (CH), Govt. of India within 3 days of completion of activity. (FAX No. 011-24366115/ 24366153).

6.6 IEC and Social Mobilization :

Effective communication is critical to ensuring that all children are immunized during IPPI. This requires a planned, intensive approach to interpersonal communication, community mobilization, advocacy, and visibility for the programme through IEC materials. Each state and district should design a communication strategy to meet three broad objectives:

- ❖ **Ensure as many children as possible are mobilized to the polio booth on Polio Ravivar and receive immunization**
- ❖ **Create community and family acceptance of the polio programme during house-to-house activities (if planned) so that no children are missed, especially newborns and children not immunized through Routine Immunization.**
- ❖ **Actively engage community groups, volunteers, civil society organization, panchayat raj and front-line workers from as many government institutions as possible to actively support the programme, especially in areas where coverage has not reached 100%. That includes ensuring that vaccinators/change agents/animators/volunteers are trained in inter-personal communication in order to be able to convince the reluctant, while maintaining the enthusiasm and support of the programme's traditional supporters.**

A national-level mass media campaign is being carried out in 2006, featuring support from the country's top celebrities.

Activities on IEC and social mobilization will be carried out in coordination with GOI, State governments, district administrations, UNICEF, WHO/NPSP, NGOs, Rotary, Panchayati Raj institutions, Education department, Information and Broadcasting department, ICDS, key religious institutions and others to expand the reach and impact of the programme.

6.6.1 Key Strategies:

- ❖ Advocacy with policy makers for creating a sense of urgency for polio eradication in India.
- ❖ Mobilization of district/ tehsil/ political leaders to support polio eradication program.
- ❖ Focus on interpersonal communication (IPC) for raising awareness in urban slums and rural areas supplemented by mass media & print material.
- ❖ Mobilization of the panchayat system to support polio eradication, including calling of Gram Sabha to plan and ensure all children are immunized.
- ❖ High-risk area approach for programme planning, monitoring, training and social mobilization in selected areas/ districts.
- ❖ Special messages & use of different channels of communication for hard to reach groups and urban areas.
- ❖ IEC materials will be developed with a recognizable 'brand' so that the public will make a quick association with what they are seeing, reading or hearing with the polio programme. This brand has been in place for more than 3 years with a very positive effect. A CD with the IEC material prototypes will be provided to State EPI officers by the third week of February. The files are in an

open format in Corel Draw, and can be modified for state languages and to add the state logo, if appropriate. Otherwise, the materials must carry the NRHM and EPI logos. States are requested not to deviate from the prototype design and colours.

- ❖ Improving visibility of fixed centres for polio drops during NIDs/SNIDs through standardized and well-recognized sign boards/banners.
- ❖ Involvement of private sector health practitioners, Lady Health Workers and community-influencers for reporting of any suspected cases of polio/paralysis.
- ❖ Integration of routine immunization messages for different levels of communication.
- ❖ Consistency in the message. Messages that change repeatedly during the preparation will lead to confusion and decreased participation in NID/SNID.

6.6.2 Messages:

The following messages, delivered in the language understood locally, are important

- ❖ Stop polio. Make sure every child under the age of five is immunized on Polio Ravivar. If one child is missed out, the virus can still attack.
- ❖ Polio eradication is a programme for all children in India (justification builds general support and enthusiasm for the programme as it is waning, indirectly challenges rumors and fears that the programme is targeting certain children with adverse affect).
- ❖ Bring your child to the booth (builds support for booth day, explains importance of not missing out on the booth, sets platform for fixed site habit for routine immunization).
- ❖ Why repeated rounds (directly answers the most pressing question - why again and again, filling the knowledge gap on eradication).
- ❖ Supplementary - all children <5 years of age should be vaccinated regardless of prior vaccinations. Emphasize that the risk is more in younger children (especially < under 2 years).
- ❖ It is particularly important that the youngest children (<2 years of age) are not missed, including newborns. These children are at high risk because of they are less likely to have received enough polio vaccine to protect them from the virus.
- ❖ The vaccine is SAFE – this message is of critical importance
- ❖ A child can be given OPV safely, even if he or she is sick and has fever.
- ❖ Date and location of NID/SNID.
- ❖ Importance of routine immunization.

6.6.3 Branding of the campaign :

The materials should be developed using a uniform colour (YELLOW-100%) & logos (EPI LOGO) for improved recognition of campaign material even by illiterates. Tag line of the campaign is “do boond zindagi ki”

At the Central, State, District and Block levels, it is expected that the Program managers/ CMOs and MOICs will ensure that communication activities are based on the above themes and use their discretion to fine-tune the plans and activities based on local/emerging needs and priorities.

6.6.4 Central level activities :

The IEC Bureau, MOH & FW will be responsible for media planning on national channels of DD and AIR, as well as media planning through cable and satellite, and FM channels. The Bureau will use software, featuring celebrity endorsements, provided by UNICEF as follows:

(a) Television :

- ❖ Develop or re-date existing video spots (New spots to be developed as per the communication need).
- ❖ Develop a media plan for national channels, including Doordarshan and satellite channels.
- ❖ Book paid airtime for telecast of TV spots on DD1, DD2 and satellite channels.

(b) Radio :

- ❖ Develop or re-date audio spots (New spots to be developed as per the communication need).
- ❖ Develop a media plan and book paid airtime for broadcast of radio spots on FM and AIR stations.

(c) Print :

- ❖ The central IEC division will prepare and release press advertisements prior to and on Polio Ravivar.
- ❖ The content of the press-advertisement will be in synchronization with the theme of the television and radio materials.

6.6.5 Preparation and Distribution of IEC materials :

(a) State-Level Activities : The State IEC Bureau, in coordination with UNICEF, WHO and Rotary where appropriate, should take primary responsibility for creating public awareness for the polio immunization rounds through the mass media, and facilitate greater public participation and acceptance for the polio eradication program. Towards this in coordination with partners, State IEC Bureau will undertake the following tasks:

- ❖ **Television (Regional Doordarshan) :** Develop a media plan and book paid airtime for **telecast of TV spots/programs** on Doordarshan (local Kendra's) and satellite channels. A 30 second and 10 second television spot, and 30 second radio spot, are being prepared at the national level in various regional languages. One Master betas and radio spools can be sent to states upon request. Requests should be forward to: pkverma@unicef.org with complete return address including PIN code for courier dispatch of Master tapes. Further duplication can be done at the state level, and distributed to broadcasters.
- ❖ **Radio (AIR) :** Book paid airtime for **broadcast of Radio spots** on FM and AIR primary and local radio stations/channels .

- **STATE IEC Bureau** will coordinate with AIR officials to ensure that the broadcast plans cover all the high-risk districts. To maximize reach and impact, all the **relevant** AIR primary/local stations/channels should be used.
 - Separately, MOHFW/GOI will send a written request to AIR to mount special programs/announcements in the slots, which are free/prepaid by MOHFW/GOI.
 - ❖ **Press** : State IEC Bureau will prepare and release press advertisement on the upcoming round. The press-ad should **be released in selected newspapers** with high readership in the high-risk districts.
 - The content of the press-advertisement will focus on the theme of the mass media campaign.
- (b) **IEC Materials** :
- ❖ **Audio cassettes for miking in districts/blocks**: Audio cassettes for the miking activities will be produced and distributed to the CMOs. State IEC Bureau will coordinate with partners to ensure **timely production and distribution** of the tapes to the block-level.
 - ❖ **Poster and banner**: The State IEC Bureau will coordinate with partners to ensure timely production and distribution of all the IEC materials i.e. banners/posters etc. to all the districts using the approved prototypes provided in advance.
 - ❖ **In coordination with partners**, state IEC bureau will issue a letter with detailed IEC matrix to the entire district stating distribution plan of all the materials produced by other partner agencies with quantity and date of delivery to final destinations.
- (c) **Distribution of materials** : State IEC Bureaus should procure IEC materials at the state level for distribution to districts. This will ensure consistency in production and messaging, and timely delivery of the materials. Materials should be placed with district Chief Medical Officers **15 days** in advance of the NID.
- (d) **IEC Funds Distribution** : State IEC Bureau to ensure that the funds for the district and block-level IEC activities reach at least a week in advance of the start of the polio immunization round.
- (e) **Building partnerships** : Considerable effort is required at the state level to forge a wide partnership for polio eradication. This includes all government sectors, the Panchayat system, private sector, NGOs, media, professional associations such as the IAP/IMA, religious organizations and others as appropriate. The State IEC Director should convene a regular partners' meeting two months prior to each NID/SNID to map partner resources and to assign key social mobilization activities.
- (f) **Ensuring visibility** : The State IEC Director should convene a small working group of partners to plan and carry out activities involving high-level political, social and cultural support for the programme. This would include involving the Chief Minister and ministers for pre round and round activities, mobilizing celebrities as polio ambassadors who will make public appeals for immunizing all target children. Activating social/ religious leaders to mobilize larger networks to work for polio eradication in underserved communities should also be undertaken.

6.6.6 District-Level Activities :

In coordination with the district administration, the district health department, the block MOICs other partner agencies and the CMOs will plan and conduct intensive local-level IEC and social mobilization activities, especially in designated high-risk blocks, to facilitate greater public participation and acceptance for the polio eradication program. District Task Force shall establish a media sub committee to plan, coordinate and oversee implementation of IEC and social mobilization activities in the district. Local mobilization activities should include special efforts to ensure that all children below the age of 5 years are reached during the Polio immunization rounds.

Towards this, the following activities will be undertaken:

- ❖ **District IEC/Social Mobilization Plan:** In coordination with local partner agencies, develop a detailed district IEC/Social Mobilization micro plan. Plan to be finalized in consultation with the District Task Force on Polio Eradication. The plan needs to be integrated into the programme micro-plan so that both activities are clearly identified together. This will allow for gaps to be identified, and for the best utilization of resources. The District Magistrate and Chief Medical Officer need to make every effort to consult with religious leaders, particularly from minority communities, to ensure their participation in the polio programme. Religious leaders need to be requested to review the microplans, ensure that volunteers from the minority community attend the booth and work with vaccinators during house to house activities, and make their own appeals through local channels.
- ❖ **Disbursement of Block Funds:** Based on the funding norms, and after making basic provision for conducting the district-level activities enumerated below, funds will be disbursed to all blocks well in advance of the start of the round. A briefing, on the block-level activity and funding guidelines, will be conducted for the MOICs by the CMO.
- ❖ **IEC Materials:** The following activities will be coordinated at the district level:
 - District HQ will take responsibility for distribution and actual usage of banners/poster/flyer/leaflet. All the materials should be distributed to the blocks well in advance of the polio immunization round. District HQ will ensure that the posters and banners are **put up at least 3 days prior** to the round at all prominent places in villages and mohallas.
 - District HQ will distribute the audio cassettes provided to all the Block MOICs for use in the miking activities. Number of miking units will be as per budget norms mentioned in budget guidelines.
- ❖ **Local Press-Advertisement:** CMO Office will prepare and release one local Press-advertisement announcing the upcoming round in the **local newspapers**. The local press-advertisement **should not be released in prominent state-level newspapers** as press-ads in these will be **released directly by the State IEC Bureau**. From **DMs** office district Information Officer will provide update and press releases to local journalists prior and during the polio immunization rounds.
- ❖ **Press Briefings :** Under the Chairmanship of DM/CMO, a press briefing/sensitization meeting will be organized for all district-level journalists, a day or two in advance of the round. The briefing will focus on status of the

polio eradication program, and the need for the upcoming house-to-house immunization rounds. The NPSP SMOs will provide all necessary supportive/technical data.

- **Local AIR Radio Station and Cable-TV Mobilization:** DM/CMO Office should mobilize local AIR stations and cable-TV operators to place polio announcements/messages in local programs and cable channels.
- ❖ Mobilize local cable-operators and cinema theatres in urban/peri-urban areas to screen polio messages in the local cable-TV network and cinema theatres.
- ❖ **Distribution of materials :** DM/CMO will ensure that all the materials are dispatched well in advance (10 days prior to the round) to blocks with a copy of usage guideline.

6.6.7 Block Level Activities :

Block MOICs, will plan and conduct intensive local-level IEC and community mobilization activities, especially in identified high-risk and resistant pockets, to facilitate greater community participation and acceptance of Oral Polio Vaccine. Monitoring data indicates that a significantly large proportion of infants/newborns continue to be missed, and therefore local mobilization activities should include special efforts to ensure that these children are reached during the rounds. Towards this, under the leadership of the Block MOIC, the following will be undertaken:

- ❖ **IEC/Social Mobilization Microplans :** At least one month in advance of the rounds, a block level microplan will be finalized. The microplan will especially include the following:
 - Listing of high-risk pockets and outreach areas requiring special efforts.
 - Detailed route-charts/schedules for miking activities, prioritizing high-risk pockets.
 - Deployment-chart of all local community mobilizers and volunteers, ensuring that all high-risk pockets are covered for community mobilization activities.
 - Listing of influencers such as community/religious leaders, gram pradhans, and medical practitioners.
 - Listing of all prominent fixed-site PA systems such as mosques and temples.
 - Miking to be carried out by slow-moving vehicles such as cycle-rickshaws/cycles and not from fast moving vehicles. Miking must be conducted in villages prior to the arrival of a vaccination team. Miking vehicles/drum-beaters must follow the route-charts. Fixed-post miking in mosques/temples to be mobilized for making live announcements at least thrice a day, on all 7 days. Announcements might also be arranged using regular PA systems at railway stations, bus stands and other public transport systems.
 - Facilitate and coordinate the efforts of all local mobilizers and NGO volunteers to maximize impact in high-risk and resistant areas.
 - Conduct mobilization meetings with local influencers such as community/religious leaders, gram pradhans and panchayat members (especially women panchayat members), and local medical practitioners. School

children should also be mobilized to encourage families and neighbours to bring their children to the booth.

- Microplans need to include the names of local influencers, community mobilizers and religious leaders who will be working at the booth, or during house to house activities, to mobilize children.
 - Mobilize local cable-operators in urban/peri-urban areas to screen polio messages in the local cable-TV network and cinema theatres. Similar messages can also be given through the telephone system.
- ❖ **Distribution of IEC materials** : Ensure that IEC materials are distributed well in advance as per the IEC guidelines. Ensure **pasting of POSTERS** in entire districts. Emphasize more in high-risk villages/mohallas, schools, mosques/temples, prominent places like local markets/haats etc.

Mobilize local cable-operators and cinema theatres in urban/peri-urban areas to screen polio messages in the local cable-TV network and cinema theatres

6.7 Review of Micro plans :

Review and updation of micro plans is critical for implementation of good quality NIDs/SNIDs rounds. The review is essential before each round to identify deficiencies/shortfalls based on the observations of previous rounds, incorporate appropriate changes and interventions for improved implementation of subsequent rounds.

General Principles:

- ❖ A micro plan would exist at most places. As far as possible review and make improvements in the existing microplans rather than start to make new plans.
- ❖ The existing microplans used in the NIDs/SNIDs should be reviewed along with the data generated in the recent rounds and feedback from monitors, central and state observers, medical officers, district and block level supervisors and vaccinators, to make suitable amendments in the microplans.
- ❖ Delegation of planning responsibility to the appropriate administrative level e.g., block or PHC or urban area where the activities will take place. Each block/PHC/urban area should be taken as the basic unit for microplanning. It should be further sub divided into supervisor's areas and these into vaccination team areas.
- ❖ Microplans should be developed and reviewed with the vaccinators, supervisors, immunization officer, block medical officer, community mobilizers, field volunteers (if available) and surveillance medical officer (SMO) sitting together.
- ❖ Block medical officers and supervisors should be responsible for planning of NID/SNID activities for their areas.
- ❖ All habitations and all houses in block/urban area jurisdictions should be included in the microplans. Microplans must target all children less than 5 years of age, including newborns.

- ❖ The national guidelines regarding number of booths, number of houses/ team/day and planning number of vehicles, logistics and IEC etc as per financial guidelines, should be considered and adapted to local needs. The adapted plans should be communicated to the higher levels.
- ❖ Plans should be based on local conditions, accessibility, geography, population movements, working hours (when are people available at home?) culture, etc. in the catchment area.
- ❖ Meetings should be held with village pradhans (councillors in urban areas), sarpanches and other local influencers to get their inputs on the local conditions while developing or reviewing the microplans.
- ❖ Micro plans should be prepared in local language so that vaccinators, supervisors and immunization assistants can follow them easily.
- ❖ NID/SNID activities can only be of high quality if microplans are based on local capabilities and constraints

6.8 Use of Data for Planning Actions :

It is essential to use the existing data for identifying actions required to plan and implement NID/SNID immunization in the area.

6.8.1 Surveillance data :

Surveillance data pertaining to wild polio cases in the recent past (as of last six months) helps to identify geographical areas where transmission of poliovirus is occurring and gives guidance for planning more intense immunization activities in such areas. The immunization history of AFP cases also provides some indications of past immunization activities. Areas where AFP cases with low number of OPV doses are reported, indicate that children have been missed during the past immunization rounds and thus helps to identify geographical areas requiring improvement in activities for the current NID/SNID.

6.8.2 SIA Data :

- ❖ Existing micro plan of the area with data on: -
 - Total houses in the area and number of childrens less than 5 years of age immunized.
 - Name of villages and their hamlets/ Name of all urban mohallas/ localities. If these lists are not available they should be developed with inputs from census data, revenue records, local municipal bodies, elected representatives etc.
- ❖ List of high risk and underserved areas.
- ❖ List of areas missed in the previous rounds.
- ❖ Feedback on the past NIDs/SNIDs or mop up rounds (from all sources such as: monitors, central or state observers, medical officers, supervisors and vaccinators).
- ❖ Data derived from analysis of tally sheets, supervisors' P sweep formats and reporting formats.
- ❖ List of available vaccinators and supervisors with department wise break up.
- ❖ List of Anganwadi (ICDS) centres in the area with available manpower.

- ❖ Available cold chain equipment
- ❖ Available vehicles
- ❖ Map of the block

6.8.3 Major sources of SIA data :

- (a) Microplans
- (b) Vaccinators Tally sheets
- (c) Supervisors and monitors feedback

(a) **Microplans:** The h-t-h activity microplans provide useful information on:

- ❖ Number of h-t-h teams deployed
- ❖ Workload of each h-t-h teams for each day
- ❖ Composition of teams
- ❖ Whether all villages/hamlets/urban areas are planned to be covered including the areas found missed in the previous rounds.
- ❖ Teams deployed to cover areas at special risk

(b) **Vaccinators tally sheets :** The various basic data that can be derived from the vaccinators tally sheets are as follows:

- ❖ Number of children immunized in houses and outside houses by each team during the entire activity and also during each day of activity
- ❖ Number of houses visited by each team during the entire activity and also during each day of activity.
- ❖ Child: House ratio (number of children immunized by teams per house)
- ❖ Number and percentage of 'X' houses generated by each team
- ❖ Number and percentage of 'X' houses revisited by teams to immunize children.
- ❖ Number and percentage of 'X' houses left at the end of activity

All the above information should be collated for each supervisor area and for the block. The information derived should be used to identify areas for interventions as follows :

- Trends of gross changes in number of children immunized, houses visited, child: house ratio should be investigated to identify reasons and appropriate actions should follow.
- Very low generation of 'X' houses in a block or supervisory area or team area denotes that the house-to-house activity has probably not been of good quality. If the teams work correctly there would be some generation of Xs. Very low generation of Xs should, therefore, lead to actions like intensive monitoring in the area and retraining of vaccination teams.
- High X houses left at the end of activity could be due to absence of children at home or a weak mechanism for revisits to X houses or failure to immunize children for various other reasons like refusal to accept OPV. Appropriate actions in the form of strengthening mechanism to revisit X houses or improving social mobilization efforts need to be undertaken.

(c) **Supervisors and monitors feedback:** The information derived from supervisors and monitors feedback is:

- ❖ Percent false P houses detected by supervisors
- ❖ Percent false P houses detected by monitors

The data on % false P houses detected is one of the most important indicators of performance of vaccinators. High false P houses in an area could be due to one or all of the following reasons:

- Problems of microplanning such as irrational workload of teams or improper composition of teams.
 - Problems of training resulting in lack of understanding of how to search and vaccinate all less than 5 years children before marking houses as 'P' or lack of motivation to do a complete job of searching and vaccinating all children in the area.
 - Lack of proper supervision of vaccination teams.
- ❖ **Actions to be taken following detection of high false Ps should be based on the underlying reason. It should call for:**
- Analyzing the workload of each team for each day to rationalize the workload by increasing teams or redistributing workload amongst existing teams.
 - Re-look at the composition of teams to have teams suited to the locale; which may mean having at least one female vaccinator in teams and/or having a team member of the same religion as the area in which team is working and /or having a member of the local community working as a team member.
 - High false Ps due to improper training and lack of motivation should be addressed by retraining of vaccinators by good quality trainers, ensuring attendance during trainings of all vaccinators who did not perform well during the recent rounds and also all vaccinators who are participating in the programme for the first time.
 - Address supervision issues by retraining and motivation of the supervisors to explain the criticality of their role.
 - Other actions like reducing the number of teams for supervision and having all teams of a supervisor working in a close geographical area (sector approach) need to be considered for improving supervision.
- ❖ Areas with operational problems in terms of:
- Missed areas
 - % teams with vaccinators not as indicated in microplans.
 - % teams with inappropriate composition of teams.
 - % teams with inadequately trained members.
 - % teams not vaccinating children outside of houses.
 - % supervisors not cross checking the work done by the teams.
 - % areas with clusters of houses missed by teams.
 - % teams not conducting bi-phasic activity.

- ❖ Assessment of transit points and special areas by analysing:
 - % transit points and special sites not included in the micro plans.
 - % transit points and special sites with inadequate teams deployed.
 - % transit points and special sites not seeking children proactively.
- ❖ **It is critical to analyse the data from transit points and special areas since these sites cater to large number of moving populations. Appropriate actions should be taken to strengthen the activities in these sites.**
- ❖ Percent children found unimmunized during street survey :

Data on unimmunized children found during street survey conducted at the end of house to house immunization activity should be analysed by age break-up and by various sites. This analysis helps in identifying where children are being missed. High percent of children found unimmunized during street survey indicates suboptimal quality of activity. Immediate actions should be taken by improving implementation of booth, house to house and transit team activity.

Percent houses with potentially missed children (commonly called percent missed houses) : This indicator is derived by adding the % X houses left at the end of the activity (data from tally sheets) and % false P houses detected by monitor (data from monitors formats).

$$\begin{aligned} \% \text{ Missed houses} &= \% \text{ X houses left at the end of activity} \\ &+ \% \text{ false P houses detected by monitors} \end{aligned}$$

Data on percentage of missed houses should be looked at for recent rounds. High percentage of missed houses indicates the probability of large number of children having been missed. **This data, therefore, helps to identify areas where there are problems of microplanning, training and social mobilization. It is more important to look at the data on missed houses at the block and supervisor level to pin point the geographical areas that require specific interventions to reduce the missed children during NIDs/SNIDs.**

The micro planning review forms (Form MR1 to MR3) on page number 53 to 55 are helpful in the analysis of microplans to identify the areas within blocks for interventions.



Template for Identifying Supervisors & Team areas within blocks requiring interventions

Name of Block/Urban area: _____

Round: _____

| Name of Supervisor | Number of houses visited by teams | Number of children immunized by teams | % X houses generated by teams | % Remaining X houses at end of activity | % False P houses | Any operational problems |
|--------------------|-----------------------------------|---------------------------------------|-------------------------------|---|------------------|--------------------------|
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Template for planning interventions

Name of Block/Urban area: _____

Round: _____

| Block/ Urban area | Issues/ Problems | Interventions planned | | | | Other actions |
|-------------------|------------------|-----------------------|------------------|----------------|------------------------|---------------|
| | | Microplan actions | Training actions | IEC/SM actions | Administrative actions | |
| | | | | | | |
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7. ACTIVITY SCHEDULE FOR NIDs/SNIDs AT DISTRICT

| Days | Activities to be planned for NID/SNID |
|-------------------------------|---|
| 60 - 45 days before the round | <ul style="list-style-type: none"> ● District Task Force meets to review preparedness and set timeline for completion of planning activities ● Review microplans for booths, house to house, transit and mobile teams ● Identify manpower for vaccination teams ● Identify requirement of other resources like transport ● Review cold chain status ● Review plan for social mobilization ● Assign blocks to district officers |
| 45 - 30 days before the round | <ul style="list-style-type: none"> ● Review and refinement of existing microplans at blocks/PHCs/urban areas ● Plan and conduct district micro planning meeting, urban area planning meetings ● Verify functioning and availability of cold chain equipment like deep freezers, ILRs, vaccine carriers, icepacks, cold boxes etc. ● Identify ice factories/cold storages for procurement of ice or freezing of ice packs ● Place orders for procurement of logistics and printing of supervisory and vaccinators instructions, checklists and tally sheets |
| 30 - 23 days before the round | <ul style="list-style-type: none"> ● Finalize microplans including man power identification ● Blocks/ PHCs /urban areas to submit microplans to the district ● CMO, DIO, SMO to check completeness of microplans ● DTF meets to review progress in Micro planning, IEC/ social mobilization. |
| 23 - 16 days before the round | <ul style="list-style-type: none"> ● Orientation of district trainers/medical officers ● Organize meeting of community /religious leaders at district headquarters Panch sammelans / community meetings in rural areas |

| Days | Activities to be planned for NID/SNID |
|--------------------------------------|---|
| 16 - 9 days before the round | <ul style="list-style-type: none"> ● Finalize and release funds to blocks/urban areas ● Start orientation of supervisors, vaccinators and cold chain handlers ● Make supervisory visits to identified high risk pockets both in rural and urban areas to review preparedness |
| 9 - 5 days before the round | <ul style="list-style-type: none"> ● DTF meets to review preparedness and solve last minute problems ● Distribute vaccines and other logistics ● Distribute IEC materials like banners, posters etc. ● Start freezing of ice packs ● Continue orientation of supervisors, vaccinators and cold chain handlers ● Continue supervisory visits to PHCs |
| 5 - 3 days before the round | <ul style="list-style-type: none"> ● Start intensive social mobilization and media announcements ● Display IEC materials ● Continue supervisory visits to PHCs |
| 3 -1 days before the round | <ul style="list-style-type: none"> ● Start miking and public announcements from fixed sites like temples, markets etc. ● Organize rallies, prabahat pheris |
| NID/SNID All days of activity | <ul style="list-style-type: none"> ● Implement booth and house to house activity ● District task force to meet daily to review activity and take corrective actions ● Daily evening meetings at block/PHC to get feedback from supervisors and plan for corrective actions during the round |
| 1 - 2 days after completion of round | <ul style="list-style-type: none"> ● Consolidate immunization figures for the district and report to SEPIO |
| 3-5 days after round | <ul style="list-style-type: none"> ● Organize district task force meeting to review implementation of last round and plan corrective actions for subsequent round |

INSTRUCTIONS FOR SUPERVISORS' AND VACCINATORS' TRAINING

- ❖ **Before conducting the training, make sure :**
 - The training sessions have been scheduled in consultation with the Block Medical Officer.
 - The date and time for the training and the venue has been clearly conveyed to the vaccinators and supervisors.
- ❖ **Following materials will be required for the training sessions :**
 - Microplan of the block/urban area to be covered with the names of the vaccinators, supervisors and local influencers.
 - Instructions for vaccinators and supervisors and infokits.
 - Vaccine carrier and ice packs to demonstrate proper use.
 - OPV vials to demonstrate VVM and method of administration of the vaccine.
 - Marker pen to demonstrate finger marking
 - Chalk or geru to demonstrate house marking.
 - Tally sheets to demonstrate how they should be filled in.

The following should be covered in training session :

- ❖ Registration and introduction of all the vaccinators and supervisors.
 - ❖ Appreciation of the role of vaccinators and supervisors in achievements under the polio eradication programme.
 - ❖ Review of the current status of polio eradication.
 - ❖ The pre-booth and other preactivity preparations including identification and interaction with local influencers.
 - ❖ Booth day preparations
 - ❖ VVM, open vial policy and cold chain management.
 - ❖ House to house activities including
 - How to enter the home and initiate a dialogue with the family members
 - Ensuring cordiality
 - Key questions to be asked in each house
 - House marking
 - Revisits to X houses
 - ❖ IPC including responding to queries from parents (with help of frequently asked questions and role plays).
 - ❖ Procedure for immunizing the child
 - ❖ Finger marking the child
 - ❖ Tally sheet marking
- (a) **Registration :** Before starting the session that registration must be done to ensure all vaccinators and supervisors are present.
- (b) **Introduction :** All participants must introduce themselves to trainer who should also give his own introduction.

Microplan and area allocation : must be reviewed by the trainer

- ❖ Check the names of supervisors and vaccinators attending the programme to ensure that there are no replacements.
- ❖ If the absent vaccinators/or supervisors are more than 5 (five), this should be explicitly recorded so that special training sessions may be held for the left out vaccinators and supervisors.
- ❖ Trainer should assess if the vaccination teams are aware of the area to be covered by them in the forthcoming round.
- ❖ If vaccinators are not aware of the area assigned to them, trainer should note the names of such vaccinators/vaccination teams. The area assignment should then be discussed with these vaccinators after the main training session is over along with the BMO and supervisor.
- ❖ Trainer should also discuss with the teams whether :
 - They are comfortable with workload in the area to be covered by them.
 - They have any constraints/problems/concerns in covering their areas.
 - They get adequate supply of OPV and logistics in time.

Progress of Polio Eradication :

Start the session on a positive note by mentioning that the programme has reached this stage only with the active and committed support of the vaccinators. The following points must be highlighted: -

- ❖ Transmission of polio is restricted to only 2 continents – Asia and Africa.
- ❖ More than 200 countries including our neighbours like Bangladesh, Sri Lanka, Iran, and Iraq have eliminated polio.
- ❖ Progress of Polio Eradication in India.
 - 1600 cases of polio occurred in India in 2002. There was a reduction to 225 cases in 2003 and only 134 cases occurred in the country in 2004.
 - In 2005, only 66 polio cases were confirmed in the country as of 16.02.06. All this could be achieved due to the efforts of the vaccinators and their supervisors.
 - Polio transmission is now limited to Bihar and high-risk districts of western U.P.
 - Discuss the progress made in the state and district over the last 12 months.
 - We have the best chance for ending transmission of polio in 2006 with the efforts of vaccinators and supervisors.
 - To achieve this we must ensure the highest quality of activities in these areas. We must reach every house and immunize every child less than 5 years of age in all rounds of Pulse Polio programme.
- ❖ **Give feedback** on previous campaigns in the area in terms of booth locations, their selection criteria, house-to-house activities, what worked well, the positive stories and the activities that still need improvement.

Discuss booth activity, house-to-house activity including IPC, vaccine including open vial policy, proper maintenance of cold chain including VVM and finger/tally sheet/ house marking in detail as given in instructions for vaccinators. At the end of the session discuss instructions for supervisors with the supervisors attending the session.

INSTRUCTIONS FOR VACCINATORS

- ❖ Pulse Polio Immunization means simultaneous administration of oral polio vaccine (OPV) to all children less than 5 years of age. Pulse Polio Immunization helps to eradicate polio by stopping spread of the poliovirus.
- ❖ All doses of OPV administered during NIDs/SNIDs are essential for eradicating polio. No child is safe till polio is eradicated.
- ❖ All newborns must also receive OPV dose immediately after birth and during all NID/SNID rounds.

Pre Activity preparations :

- ❖ The preparations of the activity should start at least one to two week before the scheduled dates of SIA.
- ❖ Local influencers must be identified in advance to provide assistance both in booth as well as house-to-house activity.
- ❖ Community leaders/local influencers must be identified to inaugurate the booths.

Before starting the immunization activities:

- ❖ Collect and check vaccine and vaccine carrier: -
 - Check that you have sufficient number of OPV vials for the expected number of children to be immunized in the day.
 - Check the vaccine vial monitor (VVM) on all the vaccine vials.
 - Check the vaccine carrier for hard frozen ice packs/ice
 - Check that plastic droppers which are provided are appropriate and adequate in number for the OPV vials supplied.
- ❖ Check all other logistics like indelible ink marker pens to mark children, chalk/geru to mark houses, pen/pencil along with tally sheets, identity cards/arm bands to identify yourself and vial opener to remove the aluminium seal from glass OPV vials.
- ❖ You should prepare and carry a map with day wise description of the area to be covered before starting immunization activities.

Carrying out immunization activities at booths :

- ❖ Ensure that the booths are set up in shade.
- ❖ **Creafestive look at booths** using banners, posters, balloons, buntings etc. **Repeated announcements** from booth site/religious site / chaupals etc. at different points and time during the day adds to the festive atmosphere on the booth day.
- ❖ OPV / vaccine carrier should not be left in sunlight.
- ❖ Open only one vial of OPV at a time and keep it outside the vaccine carrier. Keep using it till vaccine is finished. Recap the nozzle of OPV vial with plastic cap after use.
- ❖ Do not replace the vial back into the vaccine carrier after each child is immunized. Read VVM to make sure vaccine is good.

- ❖ Ice pack should not be removed from the vaccine carrier to keep the OPV vial outside the vaccine carrier.
- ❖ Avoid opening the vaccine carrier frequently.
- ❖ Immunization of children shall be on a first come first served basis
- ❖ One member of the vaccination team at the booth must receive the parents with their children and immunize all eligible children including newborns with 2 drops of OPV.
- ❖ Every immunised child must be marked with indelible ink marker pen on left little finger. The mark should cover the entire nail bed and adjoining skin on the finger.
 - Allow the finger mark to dry for a few seconds, to prevent it being rubbed off by the child.
 - Recap the marker pen and keep it in horizontal position to prevent it from drying.
- ❖ Another team member shall record a 'tick' mark on tally sheet after immunizing each child .
- ❖ After administration of OPV drops advise parents regarding continuation of routine immunization.
- ❖ Also remind them to bring their children on the day of booth activity of the next NID/SNID round
- ❖ Each parent should stand in line only once. Ensure one-way flow and help parents to make a queue. Control crowds by designating entry and exit points to the booth.
- ❖ In the afternoon when the inflow of parents and children has decreased two vaccinators should go to the community and mobilize children to the booth while two should stay back to immunize children coming to the booth.
- ❖ Recording of unnecessary information such as name and address of children and parents or cross checking from lists, should be avoided at the booths.

House to House Immunisation activities :

- ❖ During h-t-h activity, maps should be used to visit all houses systematically. No house should be left unvisited.
- ❖ Do not sit at a convenient place to immunize on day 2 onwards but visit all houses in your designated area and actively search for all unimmunized children.
- ❖ Enter each house. Greet the parents politely, introduce yourself, and explain the purpose of your visit.
- ❖ Enquire about the number of families staying in the house and the number of children below 5 years in each family. Find out how many of these children have received OPV at the booth. Check finger marking on these children.
- ❖ Enquire about any child under 5 years who may be away from home for reasons like:
 - Gone to school or fields.
 - Playing outside the house.
 - Visiting friends, relatives or market places and

- Accompanying parents to their place of work.
- Enquire about any newborns or infants sleeping inside the house and whether they have received OPV drops.
- Enquire about any children less than 5 years of age visiting the house. They should also receive OPV drops.
- ❖ If any unimmunized child less than five years is not at home during the time of your visit, record this on the 'X' tally sheet and plan to revisit the house in the evening or on the following days when the child would be available in the house.
- ❖ Before moving to next house ensure that every child less than 5 years of age in each household has received OPV dose during this round. If child has not received OPV at the booth, he/she should be given OPV during house-to-house visit.
- ❖ Mark every immunized child on left little finger with indelible ink marker pen. Allow the mark to dry for a few seconds.
- ❖ Advise parents regarding completion of routine immunization schedule and inform them about the next date of NID/SNID round and location of booth near their house.
- ❖ **Exercise utmost care in exhibiting polite and courteous behaviour while interacting with parents/family members. Answer all queries correctly and confidently. Do not lose patience or be impolite under any circumstances.**
- ❖ Before moving to the next house thank the parents/caretakers for their cooperation and ask them if they are sure that all children less than two years of age have been immunized since polio affects children less than two years of age more commonly.
- ❖ **A new tally sheet should be used every day. Record information on the tally sheet for every visited house and every immunized child.**
- ❖ All visited houses should be marked P/date or X/date.
- ❖ All houses marked X/date should be revisited during the round till all children in the house have been given OPV.
- ❖ House to house activity should stop only when it becomes sure that all houses have been visited and all children less than 5 years of age have received OPV drops.

House marking :

P/date: -

1. All children less than 5 years of age staying in the house **have received OPV dose** in this round.
2. This also includes children visiting the house when the immunization activity is on.
3. No child less than 5 years in the house.
4. All children in the house are above 5 years of age.

X/date: -

All or some children less than 5 years of age, **have not received OPV dose** for reasons like:

1. Children not at home for the following reasons
 - i. Away to fields, school, market places or accompanying parents to their place of work
 - ii. Visiting friends or relatives
2. Refusal
3. Locked house - **even if the family is not expected to return for a period of one to two years.**

| What to do if...? | |
|---|--|
| Vaccine and other supplies are delayed | Inform supervisor immediately. |
| Icepacks/ Ice are melted | Look for ice locally, procure it and put it in the vaccine carrier. Don't stop vaccination. Read VVM and keep giving good vaccine. |
| Vaccine is finished | Procure vaccine from nearby team, inform supervisor. |
| Tally sheets are finished | Use plain paper to record. |
| Chalks/ Geru not supplied | Procure chalks/ geru locally. |
| Parents refuse vaccination for their children | Find out reasons for their refusal, try to convince them or seek help of local community influencers. If not successful inform supervisor. |

HOW TO READ VACCINE VIAL MONITOR (VVM)



Square is lighter than circle.
If expiry date is not passed, use the vaccine



Square is lighter than Circle.
If expiry date is not passed, use the vaccine



Square matches Circle.
Do not use the vaccine. Inform your supervisor



Square is darker than Circle.
Do not use the vaccine. Inform your supervisor

COLOUR OF THE VACCINE HAS NOTHING TO DO WITH VVM, OR WITH WHETHER THE VACCINE SHOULD BE USED

INSTRUCTIONS FOR SUPERVISORS

Your role is critical to the success of the programme and effective supervision carried out by you will help reaching the goal of polio eradication. You have to identify problems and solve them on the spot.

General Instructions:

- ❖ You should be familiar with your area of supervision before the day of NID/SNID.
- ❖ You should have a plan for supervising all team areas working in your area.
- ❖ You should have maps of the area with team areas assigned on the maps.
- ❖ You must meet all teams in the morning before they start work.
- ❖ You must meet the medical officer of your area every evening to give a feedback of the work done in your area along with the checklist and map.
- ❖ You should be constantly moving in your area on the NID/SNID days.

Before the NID/SNID:

Visit the areas to be covered by teams in the areas allotted to you and familiarize yourself with (*At least 3 days prior to activity*)

- ❖ Location of booths.
- ❖ Vaccinator teams.
- ❖ Boundaries of your area and boundaries of your teams.

Check :

- ❖ Area allocation with day wise activity plan for the teams.
- ❖ Team maps and prepare supervisor's maps.
- ❖ Areas where problems were encountered in last round.
- ❖ Analyse tally sheets and feedback of supervisors and monitors from previous rounds to determine problems and problem areas.
- ❖ Plan for supply of vaccine and logistics to all your teams.

Meet :

- ❖ Community leaders (formal as well as informal) from the area and arrange volunteers to assist teams at the booths and during house to house visits.
- ❖ Team members to discuss the area allocation and special plans to cover problem areas.

Supervision of immunization at the booth/post:

- ❖ Ensure vaccine and other logistics are available at the posts/ booths at the right time.
- ❖ Ensure all teams begin their work on time and know precisely what they are supposed to do.
- ❖ Ensure mobile teams have moved out to their areas of work.

- ❖ Visit all booths three times during the day to ensure that:
 - They have sufficient supplies.
 - They are giving OPV to all target children.
 - There are no queues at the booths. In case there are queues, find out the reason. Ensure the workers are not noting down unnecessary details like name, fathers name, age etc. of children immunized. If required, you may have to send an additional worker to such booths if number of children attending the booth is very large.
 - All children are being marked on the finger with marker pen after they have received OPV.
 - Workers are marking on the tally sheet after immunizing each child . Count the number of vials used and count the number of children immunized as per the tally sheet. This will give you some indication of whether or not the workers are marking the tally sheet correctly. (Normally it is not possible to immunize 20 children from a vial).
 - Vaccine is kept properly in the vaccine carrier with sufficient icepacks/ ice. Only one vial is outside the vaccine carrier and the vaccine carrier is tightly closed.
- ❖ Workers know how to read and interpret VVM. Check the VVM of the available vials. Replace vials if VVM shows vaccine is not potent.
- ❖ Workers are giving key messages to the parents about :
 - Date of next round
 - Continuation of routine immunization
- ❖ Volunteers at the booth are mobilizing children from the community to the booth.
- ❖ When the booths are less crowded or there are no children on the booth, some of the vaccinators/volunteers go out to call unimmunized children to the booth.
- ❖ Record observations of booth supervision on Supervisors checklist for booth activities (form 7A).

Supervision of house-to-house immunization activity:

In the morning : Check that all h-t-h teams:

- ❖ Have reported to their area
- ❖ Have received vaccine and logistics. If not, report to Block MO to arrange for substitutes/vaccine and logistics
- ❖ Are clear on the area/houses that they have to visit each day
- ❖ Have begun work on time
- ❖ Check at least 5 houses along with each h-t-h team to see whether they are:
 - Making an attempt to enter all houses.
 - Determining the correct number of children under 5 years, especially newborns, toddlers and children sleeping inside the house.
 - Immunizing all children under 5 years of age in each house.
 - Marking all children after immunizing them.
 - Marking the house P/Date or X/date and filling the tally sheet as per the guidelines before moving to next household.

- ❖ **Be on the lookout for unimmunized children on the street by checking them for finger markings. Give OPV to all unimmunized children.**
- ❖ Check the areas already covered by each team.
 - Every 10th house (if you are supervising 2- 3 h-t-h teams) **or** every 15th house (if you are supervising 5 h-t-h teams)
 - Also cross check few X to P converted houses for correctness.
 - Border areas between the teams are covered.
 - Border areas with the neighbouring supervisors are covered
- ❖ Fill supervisors' tally sheet (form 7B) and submit to Block MO

In the afternoon and evening :

- ❖ Visit X houses/X clusters with the teams to immunize the children.
- ❖ Meet all your teams.
- ❖ Collect the tally sheets and review them for
 - X houses/X clusters.
 - Number of OPV vials used vs. number of children immunized.
- ❖ Discuss any problems faced by the teams in the field and suggest solutions.
- ❖ Give feedback to teams based on random checks of 'P' houses.
- ❖ Compile information and meet Block Medical Officer in the evening.
- ❖ Plan activity for the next day with all the teams.

Reaching all children less than 5 years of age, including newborns in your area is your responsibility