National Primary Healthcare Development Agency

BAYELSA STATE Training of Trainers (SToT) for April 2025 NIPDs Campaign

April 16th2025

MAY 2025 NIPDs STOT (BAYELSA STATE)

Agenda	Responsible	Time	Duration
Opening prayer	Volunteer	9:00 am – 9:05 am	5 mins
Opening Remarks	ES/DDCI	9:05 am – 9:10 am	5 mins
Objectives of the STOT	DDCI/NPHCDA SC	9:10 am – 9:15 am	5 mins
Pre-test	ALL	9:15 am – 9:25 am	10 mins
Program Update: Surveillance, RI & SIAs updates	WHO SO	9:25 am – 9:45 am	20 mins
Strategic Shift	WHO VPDs TA	9:45 am – 10:15 am	30 mins
Vaccination Strategies	SIO	10:15 am – 10:35 am	20 mins
Discussion (Q&A)/Tea Break	All	10:35 am – 11:25 am	50 mins
Quality Training for SIAs	WHO APHO	11:25 am – 11:450 am	20 mins
Team Selection	NPHCDA SC/ZTO	11:45 am – 12:05 pm	20 mins
Development of Micro plan & DIP	WHO VPDs TA	12:05 pm – 12:25 pm	20 mins
Advocacy Communication & Social Mobilization (ACSM)	STATE MOBILIZATION OFFICER	12:25 pm – 12:45 pm	20 mins
Cold chain and Logistics	STATE CCO/VSL	12:45 pm – 13:05 pm	20 mins
Implementation of High-Risk Operational Plan	WHO SO/APHP	13:05 pm – 13:25 pm	20 mins
Data Tools & Management	State M&E, Dr. Makio, James	13:25 pm – 14:00 pm	35 mins
Discussion (Q&A)/Lunch	All	14:00 pm – 14:30 pm	30 mins

MAY 2025 NIPDs STOT (BAYELSA STATE)

Monitoring & Supervision	WHO IDSR FP	14:30 pm – 14:45 pm	15 mins
Cross-border & Vaccination in Special Places	WHO APHO/SIO	14:45 pm – 15:05 pm	20 mins
Implementation of Accountability	SIO	15:05 pm – 15:20 pm	15 mins
Ethics & Integrity: Prevent, Detect & Respond to Misconduct	Ms. Onyinyechi	15:20 pm – 15:35 pm	15 mins
Discussion (Q&A)	All	15:35 pm – 15:45 pm	10 mins
Post-test	All	15:45 pm – 15:55 pm	10 mins
Budget and Administrative Announcements	WHO PA, WHO SO	15:55 pm – 16:15 pm	20 mins
Next Steps (Trainings, Mini Microplan Walkthrough etc.)	DDCI/SIO/WHO SO	16:15 pm – 16:30 pm	15 mins
Closing prayers	Volunteer	16:30 pm – 16:35 pm	5 mins

Moderators –

1. Ag. SIO
2. WHO VPDs STA
3. WHO APHO

Secretariat – WHO LGAFs (Nembe and Brass)

Timekeepers: Ogbia LGAF, Ekeremor LGAF

Rapporteurs: Southern Ijaw LGAF, Yenagoa LGAF

Opening Remarks

Objectives and Expectations of the Training

DDCI/NPHCDA SC

Objective: To strengthen trainers' capacity on the new polio campaign strategies for better planning, implementation, and monitoring of campaigns

Sub – Objectives

1. To equip trainers with skills in innovative strategies for better microplanning, team performance, and campaign monitoring
2. To promote data-driven decision-making and community engagement for better campaign outcomes

Expected outcome

At the end of this training, we will have ….

1. **Enhanced Trainer Competency:** Participants will be fully equipped to cascade high-quality training to state- and LGA-level teams
2. **Standardized Implementation:** Uniform adherence to OBR protocols, ensuring consistency and efficiency in campaign execution.
3. **Improved Supervision and Monitoring:** Strengthened capacity in tracking campaign progress, identifying gaps, and implementing corrective actions for better immunization outcomes

Pre–Test

ALL

Pre-Test NTOT

https://tinyurl.com/ntotpretestST

For Support:
WhatsApp – 07087408077

Program Update

WHO SO

Outline

- Program highlights(SIA, Surveillance & RI)
-  SIA Updates
-  Surveillance Updates
-  RI Updates

Background

- In 2024, Nigeria recorded 122 cVPV2 detections as compared to 166 detections in 2023. However, the **number of cVPV2 isolates from AFP cases increased by 9% from 2023 to 2024(86 to 98)**, underscoring continued transmission
- While the number of states affected remained the same across 2023 and 2024, we have observed **new cVPV2 detections in states such as Yobe, Gombe, Bauchi, Borno and Adamawa**
- **Campaign quality improved** in 2024, as shown by the increase in proportion of settlements reached with **geo-evidence—from 57% at R3 to 80% at R5**
- The program implemented several innovations in 2024 including - Deployment of **e-Tally** as a transition from the paper-based tally system**, providing geo-evidence of settlement reach; Settlement-based analysis;** Conduct of studies to understand the depth and drivers of fake finger marking
- However, a few challenges around a **high number of unresolved non-compliance cases**, interferences in **team selection processes**, and widespread **fake finger marking** continue to undermine the campaign quality
- In 2025, we will implement **several strategic shifts** to address the pressing challenges driving transmission

Source: Team analysis

Program Highlights

Surveillance Updates

- In 2025, **17 cVPV2 isolates** have been reported from **15 LGAs in 8 states**
- Most recent date of onset of cVPV2 was on **Feb 8,2025 from Ogbomosho North of Oyo state.**
- **2 new emergencies (VPVn)** have been reported from **Yobe & Sokoto states**
- **Additionally 1 VPV3 from an AFP case with date of onset 4th Feb 2025 from Nguru LGA,Yobe**
- Currently Seven (07) pending PV2 isolates from 06 LGAs in Sokoto, Katsina and Yobe state

RI Updates

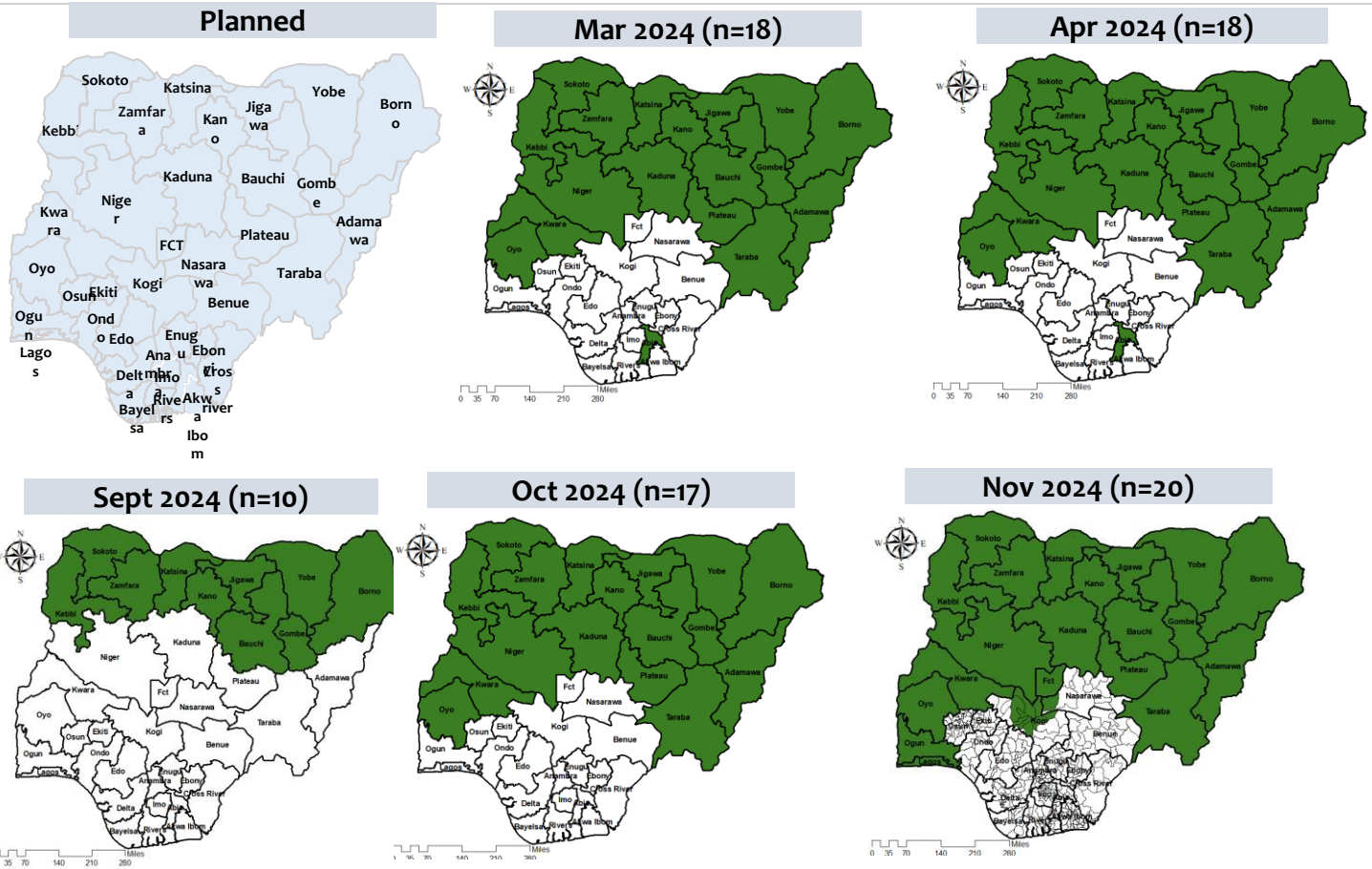
- In RI, the country reported an overall performance of **53% from the NDHS 2023-2024** with an improvement noted compared to NDHS in 2018
- The Northern zones recorded better coverage compared to other zones.
- Immunization uptake was better in urban areas compared to rural areas in both years, however rural showed improved update compared to urban
- ZDROP has been implemented in the North in 10 states & 100 ZD LGAs
- Big catch up has been implemented mostly the south, North central & North Eastern states across 200 LGAs
- **Plan to integrate RI with polio and Non-polio SIAs in the October round.**

SIA Updates

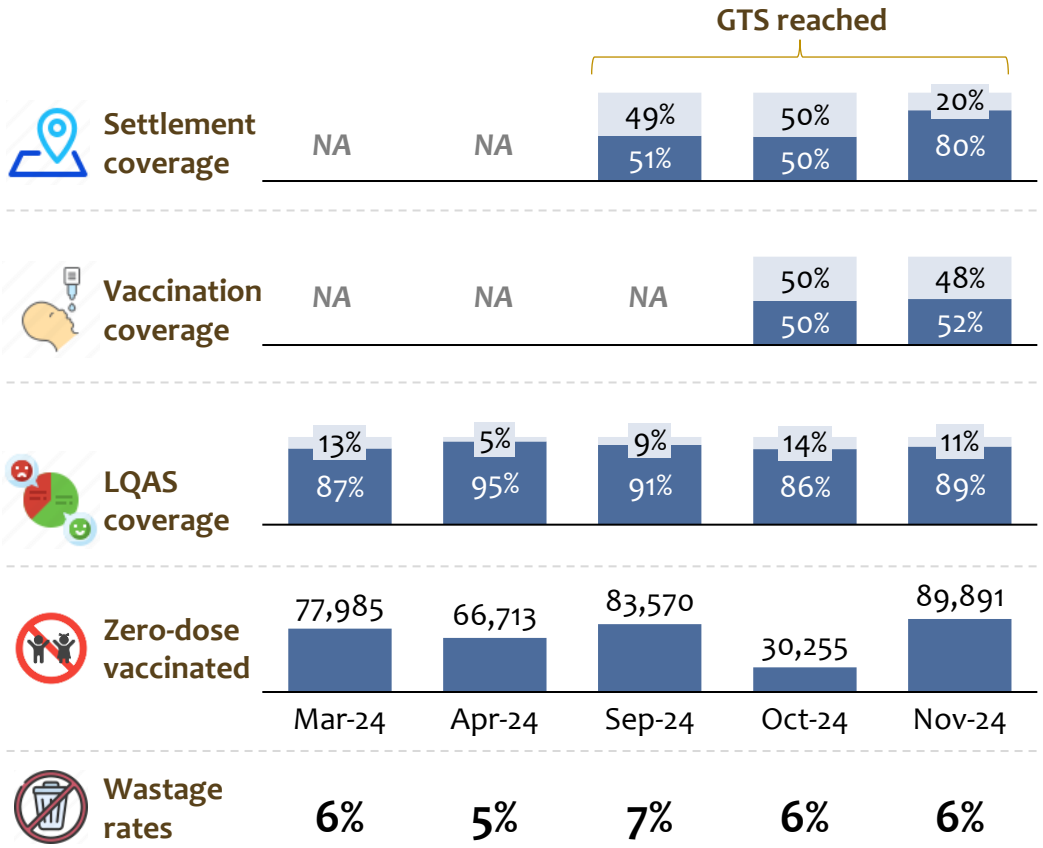
- Conducted Targeted Local Response to pending PV2 isolates in 34 LGAs of 7states - One LGA (Damaturu) in Yobe state failed the LQAS
- IE of IEV Strategy has commenced in 6 high risk priority states of Kano, Katsina, Zamfara, Jigawa, Kebbi and Sokoto implemented by third parties
- Mini walkthrough microplanning orientation to be conducted for non IEV states in selected LGAs
- In 2024, Implemented 5 OBR in 18 states
- In Jan 2025, implemented one OBR round in 3 states of Lagos, Kogi & Nasarawa
- **An immediate local response conducted in one ward (Afunori) in Nguru LGA,Yobe in response to the VPV3**

Five rounds (Mar, Apr, Sep, Oct & Nov) of SNIDs were conducted in 2024 to tackle the spread of cVPV2 across high-risk states

Map of Nigeria showing planned and reached states for the Mar, Apr, Sep, Oct & Nov SNID campaigns



Key Results from March, April, and September SNID across the 18 implementing states

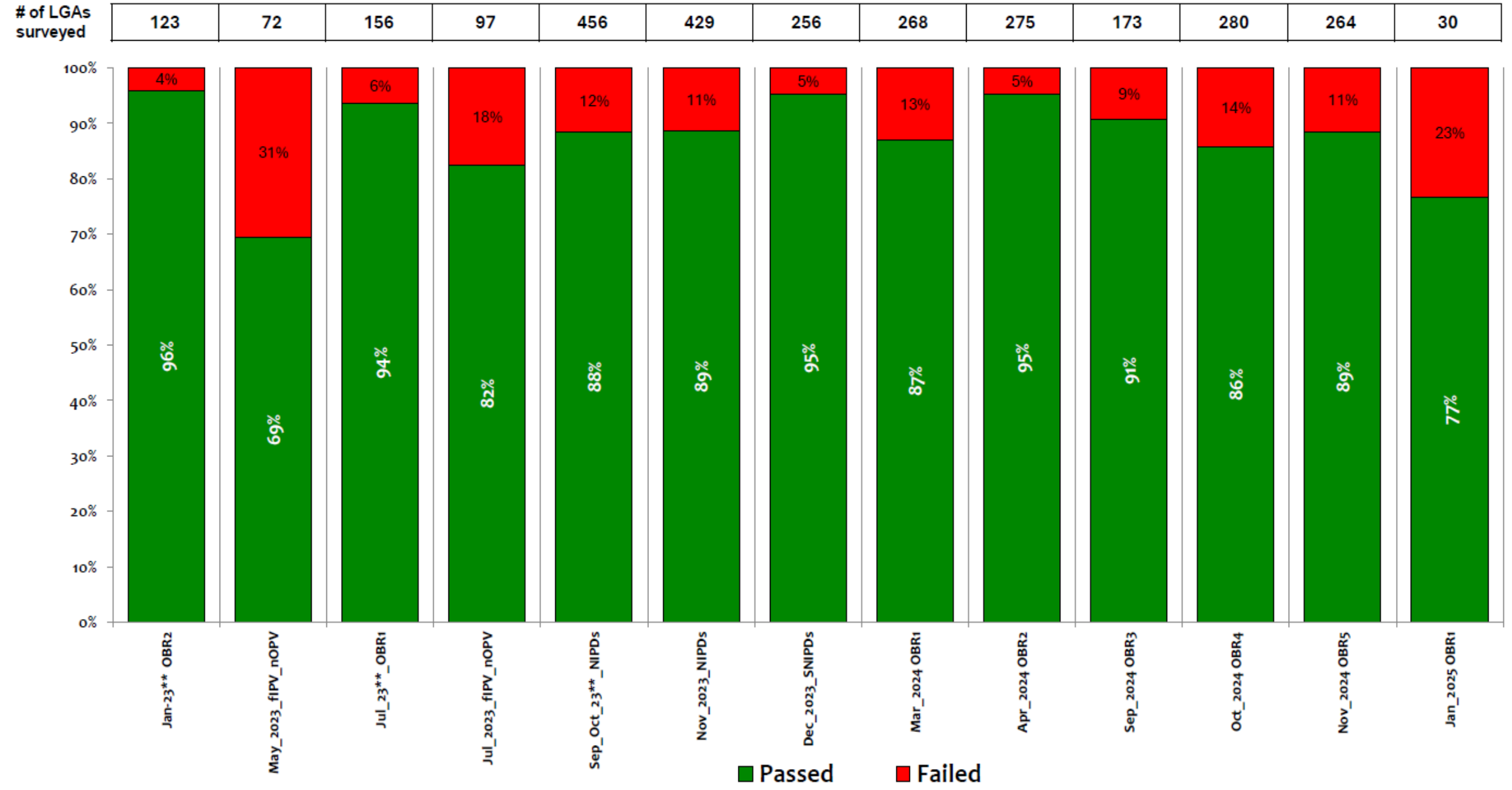


We were unable to implement the full scope of campaigns agreed upon by the ERC due to a shortage of vaccine supplies, which resulted in delayed response times and incomplete campaign coverage.

We implemented several campaign quality improvement initiatives evidenced by the improvement in the reach of settlements with geo-evidence both in security-compromised and non-security compromised areas, however we still have significant quality issues in the campaign conducted

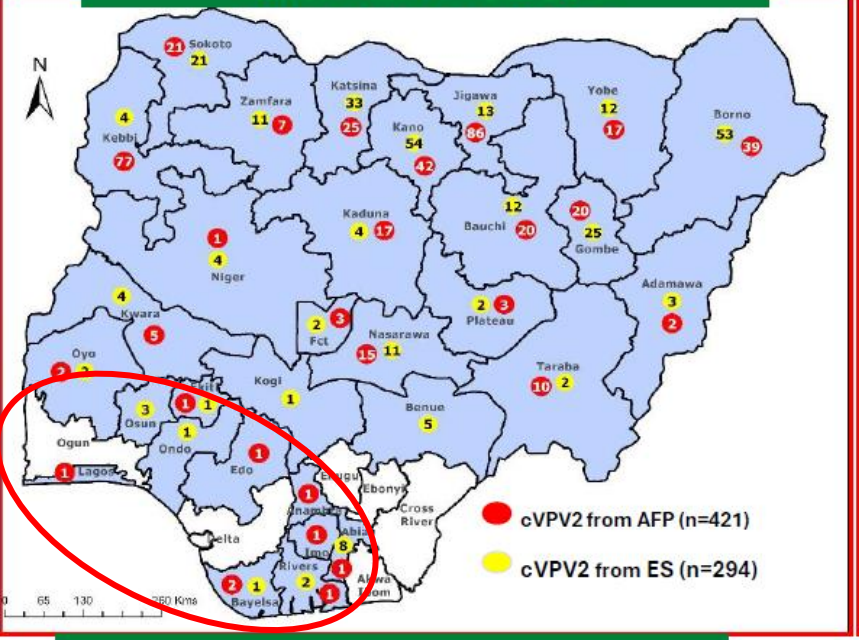
Source: GTS data, Tally sheet data, States post-campaign reports, Team analysis

LQAS Coverage by Round, Jan-23 – Jan. 2025 OBR1 3 States

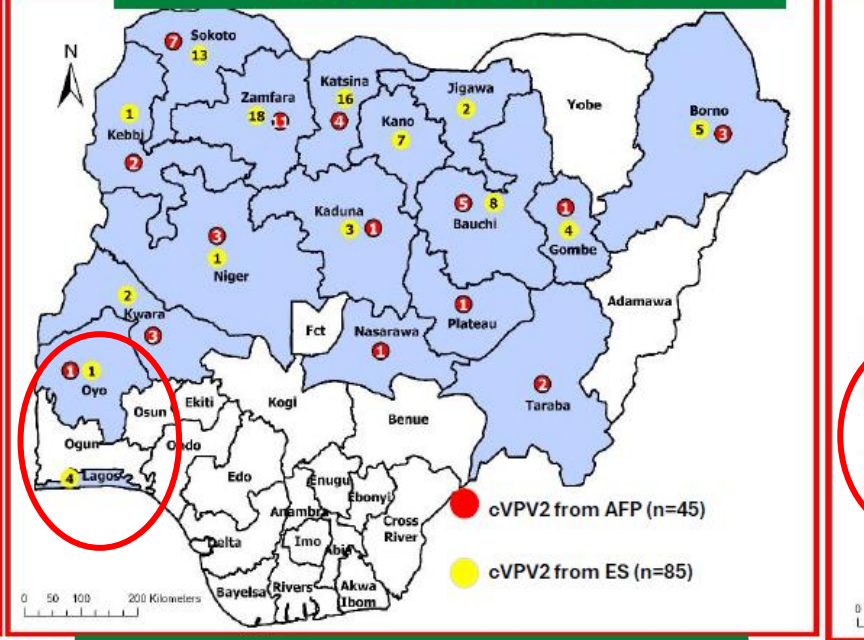


cVPV2 isolated and their distribution by states , 2021-2024 and 2025 Week 1 to 13, 2025

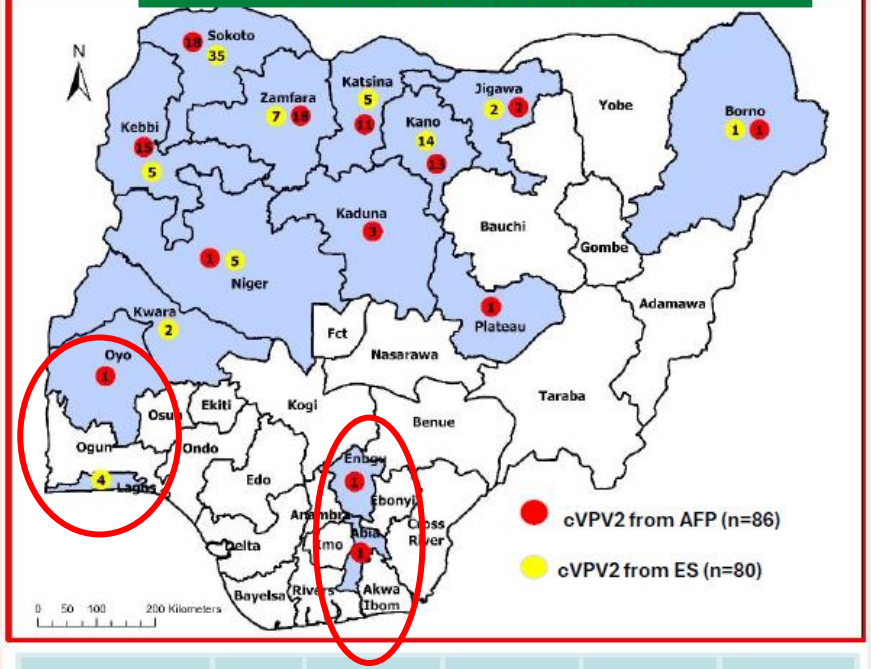
States with VPV2 in 2021



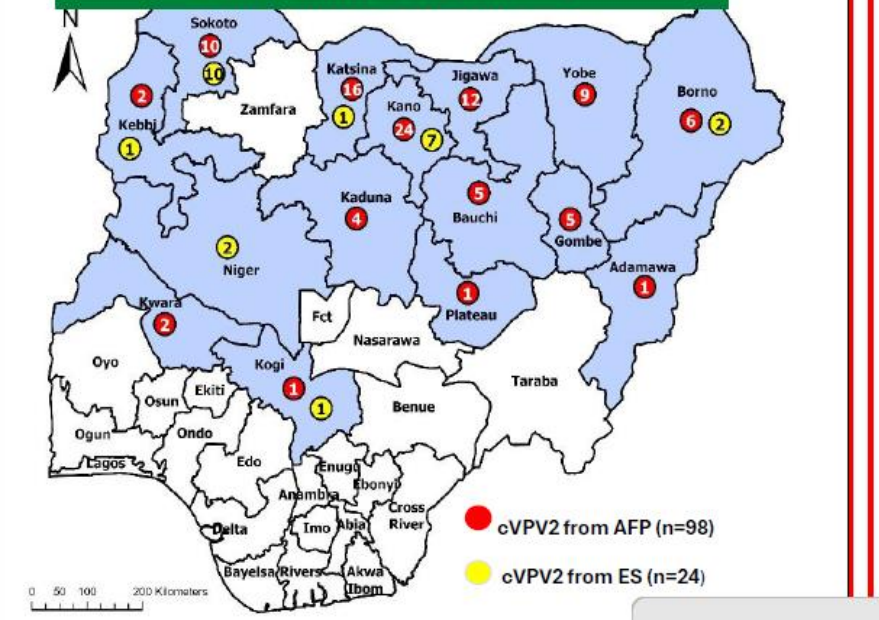
States with VPV2 in 2022



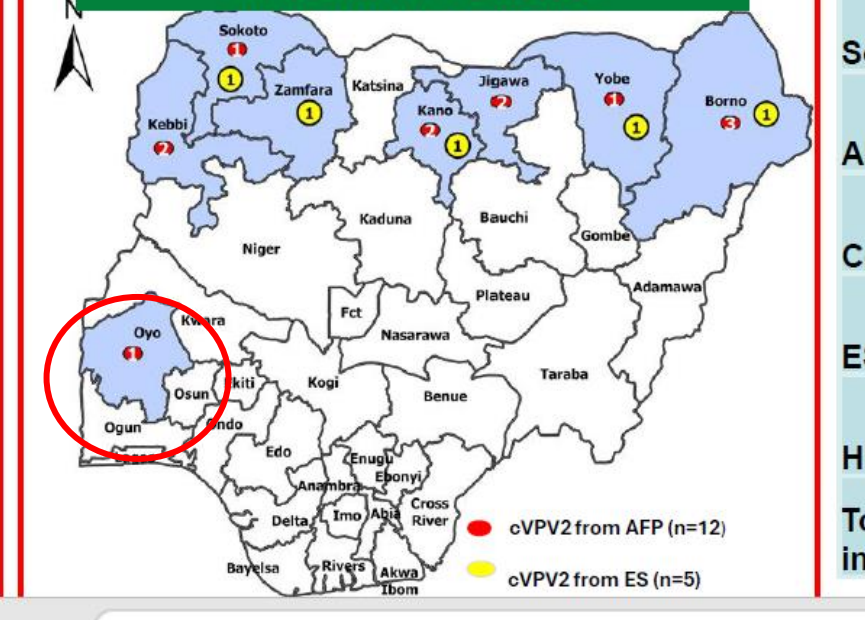
States with VPV2 in 2023



States with VPV2 in 2024



States with VPV2 in 2025



Source	2021	2022	2023	2024	2025
AFP/Index	421	45	86	98	12
Contact	313	34	59	67	6
ES	294	85	80	24	5
HC		3			
Total (AFP, index &ES)	715	130	166	122	17

Data as of 4th Apr, 2025

Southern States reported confirmed cVPV2 Isolates 2021__2025 up to week 13

2021	2022	2023	2024	2025
OYO	OYO	OYO		OYO
LAGOS	LAGOS	LAGOS		
ABIA		ABIA		
OSUN		ENUGU		
EKITI				
EDO				
BAYELSA				
RIVERS				
IMO				
ANAMBRA				

- 2021 had the most states that reported cVPV2 (10/17)
- Oyo State reported cVPV2s in 4/5 years under review with persistent transmission in 2021 - 2023.
- Lagos State reported cVPV2 in 3/5 years under review
- Abia State reported in 2/5 years under review

Distribution of cVPV2 cases in 8 states as at Week 13 2025 compared to 2024 same period (same # of affected states)

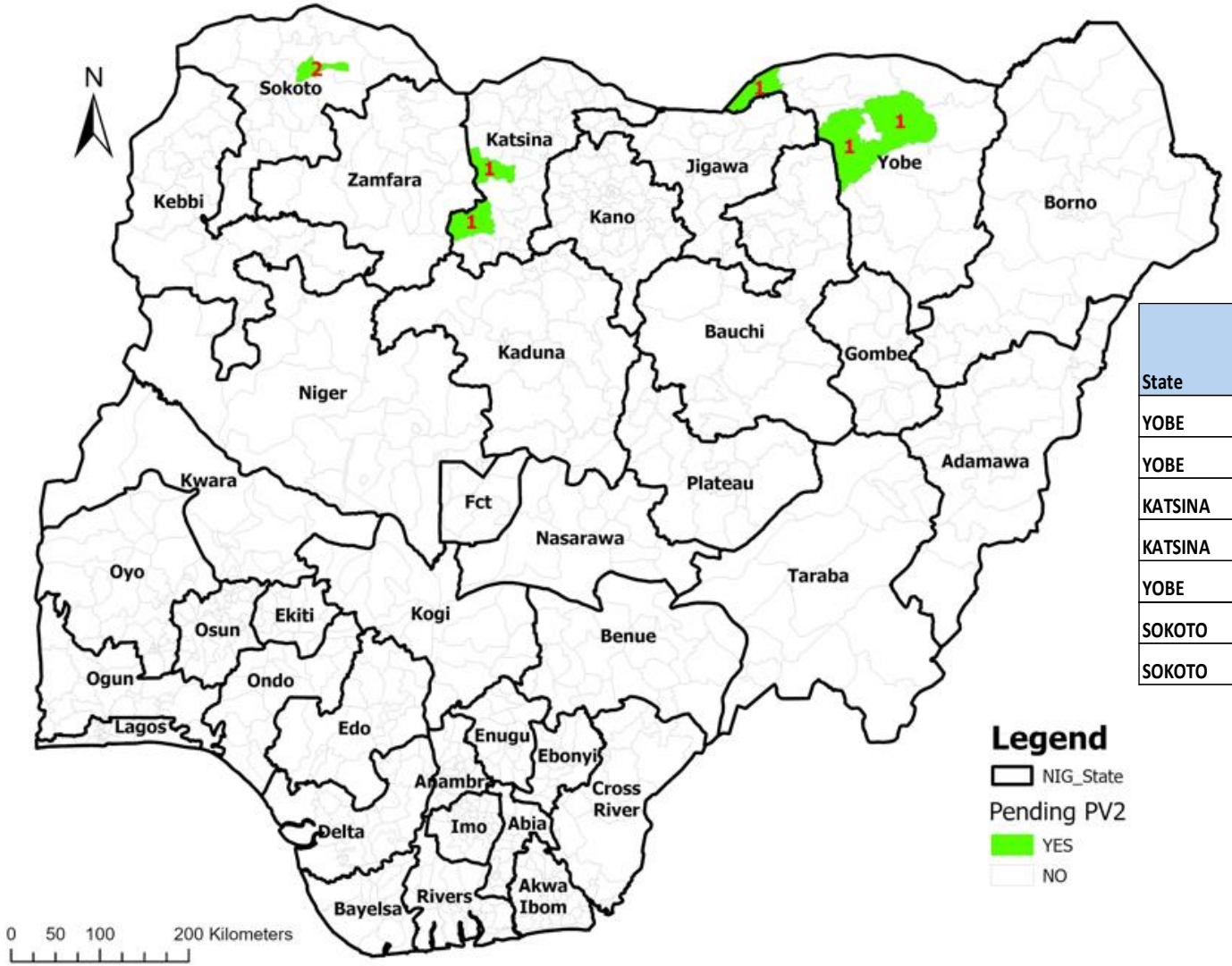
Week 13, 2024 (33 cases from 9 states)

State	AFP	ES	Total
ADAMAWA	1	0	1
BAUCHI	2	0	2
JIGAWA	1	0	1
KADUNA	1	0	1
KANO	5	1	6
Katsina	8	0	8
KEBBI	1	1	2
NIGER	0	2	2
SOKOTO	2	8	10
Grand Total	21	12	33

Week 13, 2025 (17 cases from 8 states)

State	AFP	ES	Total
BORNO	3	1	4
JIGAWA	2	0	2
KANO	2	1	3
KEBBI	2	0	2
OYO	1	0	1
SOKOTO	1	1	2
YOBE	1	1	2
ZAMFARA	0	1	1
Grand Total	12	5	17

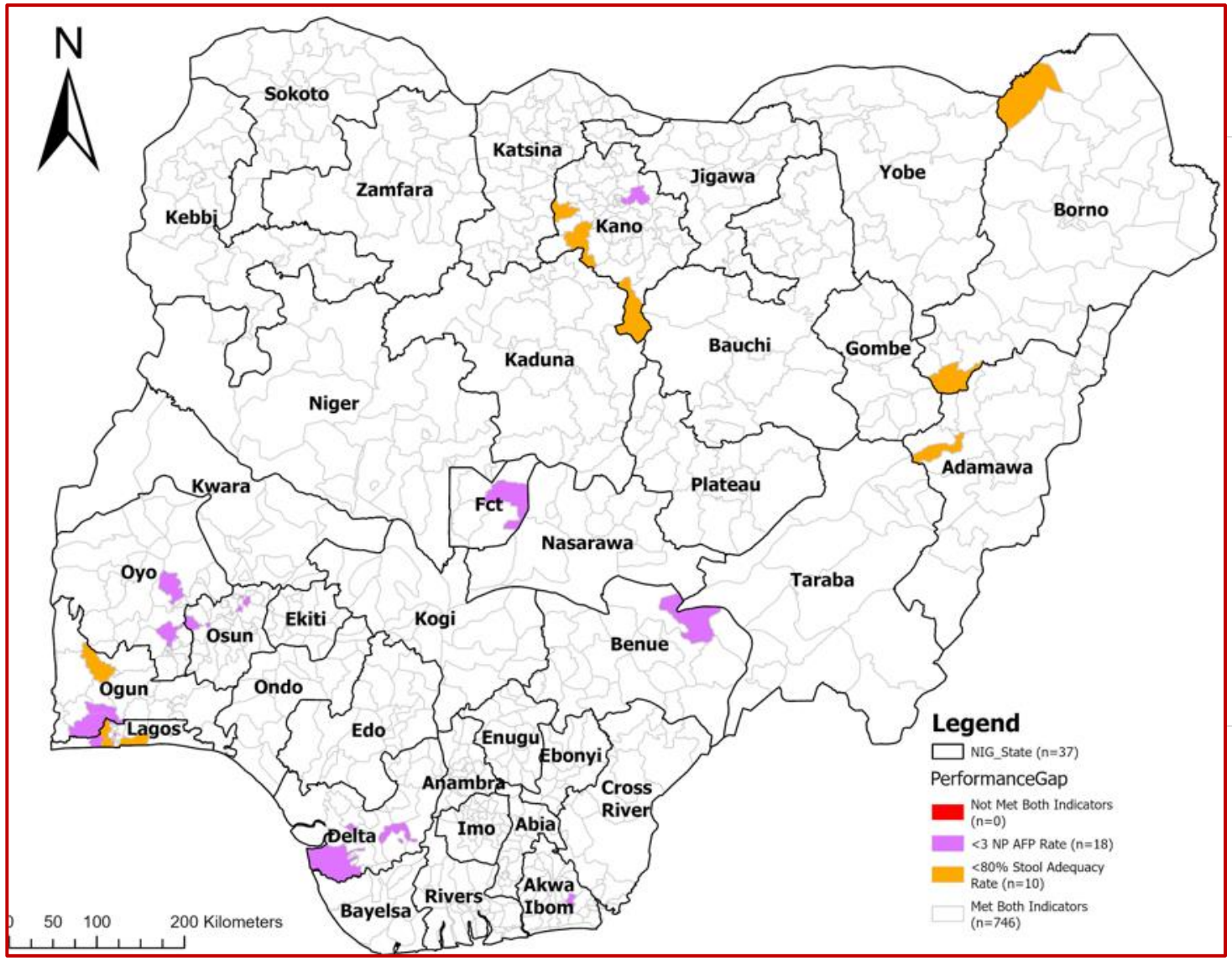
7 Pending PV2 isolates from 6 LGAs/ 3States, as at 4th Apr, 2025



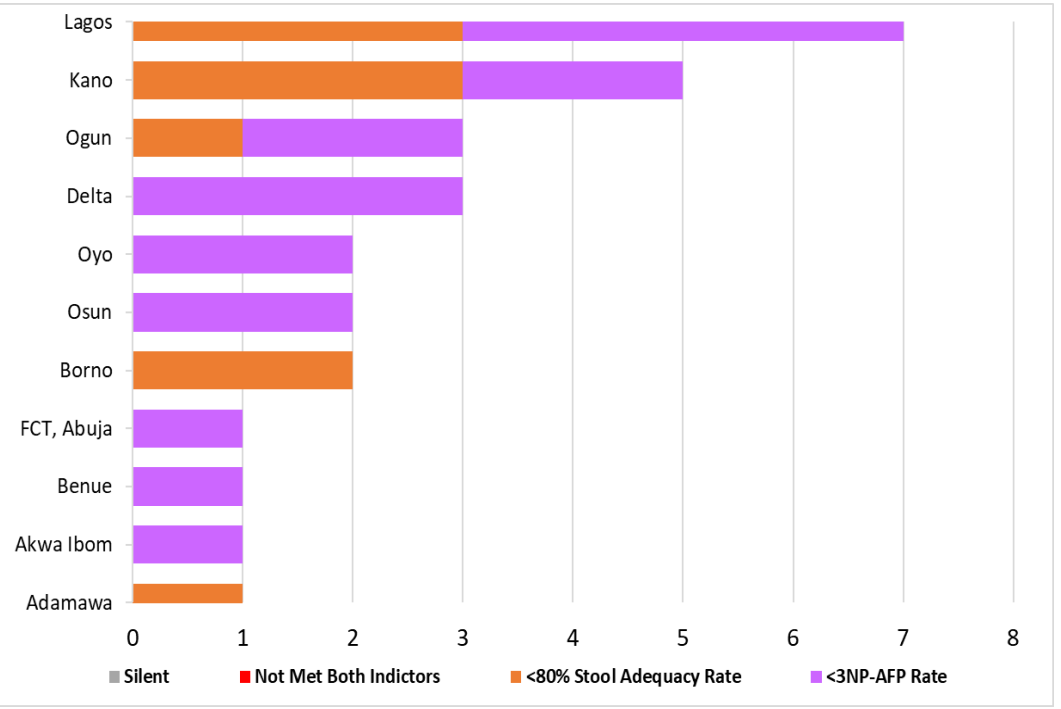
State	LGA	Wards	Epid Number	Sample Type	Date of Onset/Sample collection	Date sent for sequencing
YOBE	BURSARI	DAPCHI	NIE-YBS-DPH-25-006	Contact	15-Feb-25	10-Mar-25
YOBE	MACHINA	MASKANDARE	NIE-YBS-MCN-25-004	Contact	10-Feb-25	10-Mar-25
KATSINA	FASKARI	Faskari	NIE-KTS-FSK-25-013	AFP	20-Feb-25	17-Mar-25
KATSINA	DAN MUSA	DAN MUSA A	NIE-KTS-DMS-25-006	AFP	26-Feb-25	23-Mar-25
YOBE	JAKUSKO	Girgir/Bayam	NIE-YBS-JAK-25-006	AFP	15-Mar-25	31-Mar-25
SOKOTO	WURNO	Tunga	NIE-SOS-WRN-25-013C2	Contact	15-Mar-25	01-Apr-25
SOKOTO	WURNO	Tunga	NIE-SOS-WRN-25-014C1	Contact	15-Mar-25	01-Apr-25

Two (2) new PV2 isolates reported this week

2024/25 Rolling year AFP Core Indicators Performance by state



LGAs with Performance gap by state



- April campaign & all SIAs provide the opportunity to intensify AFP surveillance by the house-to-house teams
- Under performing LGAs don't miss this opportunity

Data as of 4th Apr, 2025

10 LGAs with <80% Stool Adequacy Rate in 2024/25 rolling year

Num	Province	District	U15 Population	#AFP Reported	Stool Adequacy (%)	NP-AFP Rate
1	Adamawa	Numan	70,208	11	73	16
2	Borno	Mobbar	98,029	22	77	22
3	Borno	Shani	85,981	8	63	9
4	Kano	Doguwa	124,971	11	73	9
5	Kano	Gwarzo	152,090	16	75	11
6	Kano	Kiru	218,877	14	71	6
7	Lagos	Alimosho	1,038,952	40	78	4
8	Lagos	Amuwo Odofin	258,711	13	77	5
9	Lagos	Eti Osa	234,008	12	75	5
10	Ogun	Abeokuta North	166,425	8	75	5

Data as of 4th Apr, 2025

18 LGAs with <3 Np-AFP Rate in 2024/25 rolling year, 4th Apr, 2025

Num	Province	District	U15 Population	#AFP Reported	Stool Adequacy (%)	NP-AFP Rate
1	Akwa Ibom	NSIT ATAI	62,685	1	100	1.60
2	Benue	Logo	133,011	2	100	1.50
3	Delta	Burutu	170,486	5	100	2.93
4	Delta	Isoko North	117,217	3	100	2.56
5	Delta	Uvwie	155,692	4	100	2.57
6	FCT, Abuja	Municipal Area Council	1,680,528	45	98	2.68
7	Kano	Gezawa	233,167	10	90	2.57
8	Kano	Nassarawa	493,226	12	92	2.43
9	Lagos	Ajeromi/Ifelodun	556,269	15	100	2.70
10	Lagos	Ifako/Ijaye	347,922	7	86	2.01
11	Lagos	Mushin	514,721	15	87	2.91
12	Lagos	Ojo	486,312	14	93	2.88
13	Ogun	Ado Odo/Ota	435,276	10	80	2.30
14	Ogun	Ifo	433,847	11	100	2.54
15	Osun	Boripe	113,317	3	100	2.65
16	Osun	Iwo	155,615	3	100	1.93
17	Oyo	Akinyele	177,614	5	100	2.82
18	Oyo	Atiba	142,608	4	100	2.80

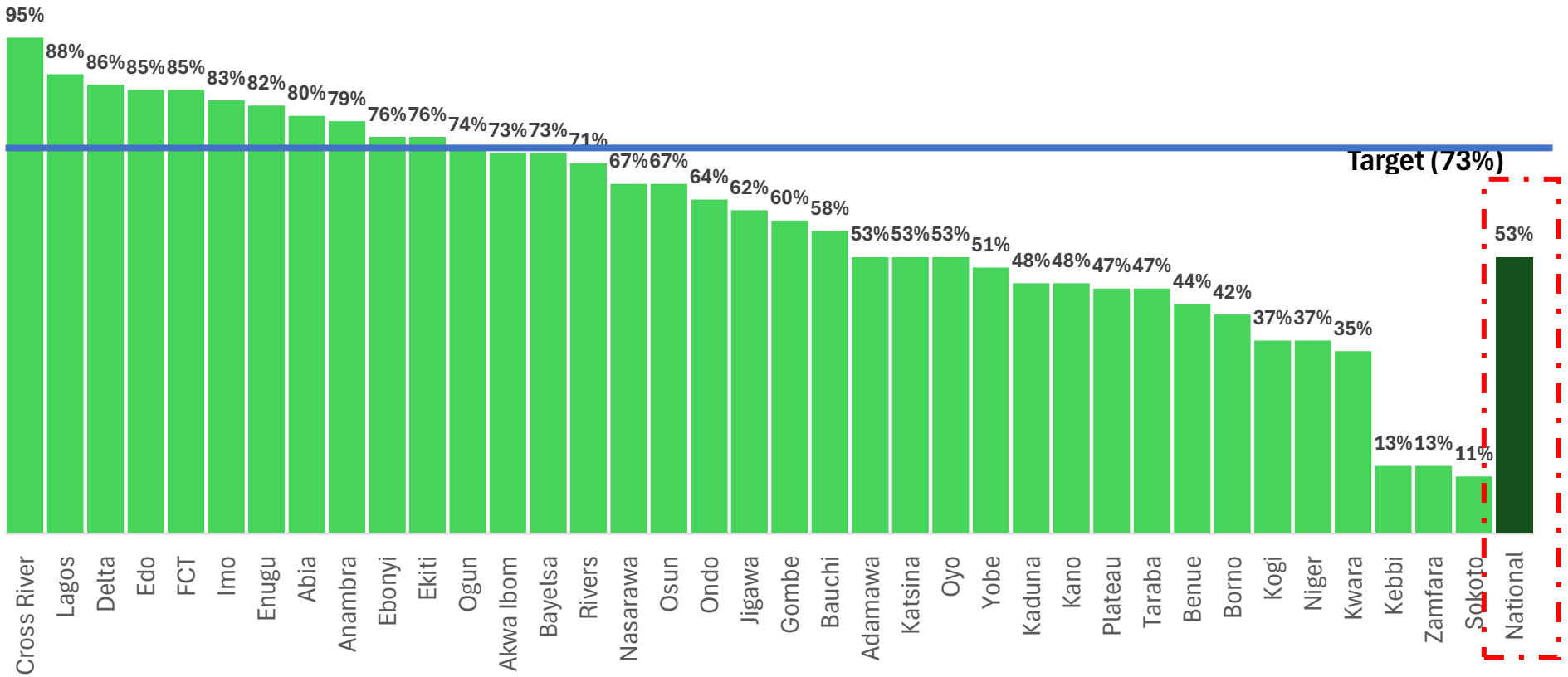
Data as of 4th Apr, 2025

Surveillance Intensification during SIAs & Long-term

- **SIAs**
  - Train vaccination team members on identification and reporting of AFP cases during H2H
  - AFP pictorials to be provided to each team supervisor
  - AFP cases identification should be discussed daily at ERM by the vaccination teams
  - Contact details of DSNO should be shared with the teams & right information to share-AFP reporting

- **Long term**
  - Weekly tracking of active surveillance visits to focal sites as guideline
  - Review health facility contact analysis to identify additional new focal sites
  - Retroactive case search in health facilities and community active case searches in silent wards
  - ES collectors and supervisors to ensure that ES samples are collected at time of peak flow.
  - Regular desilting of ES sites to be ensured

RI Performance of States



Source: NDHS 2023-2024 report (Penta 3 Coverage)

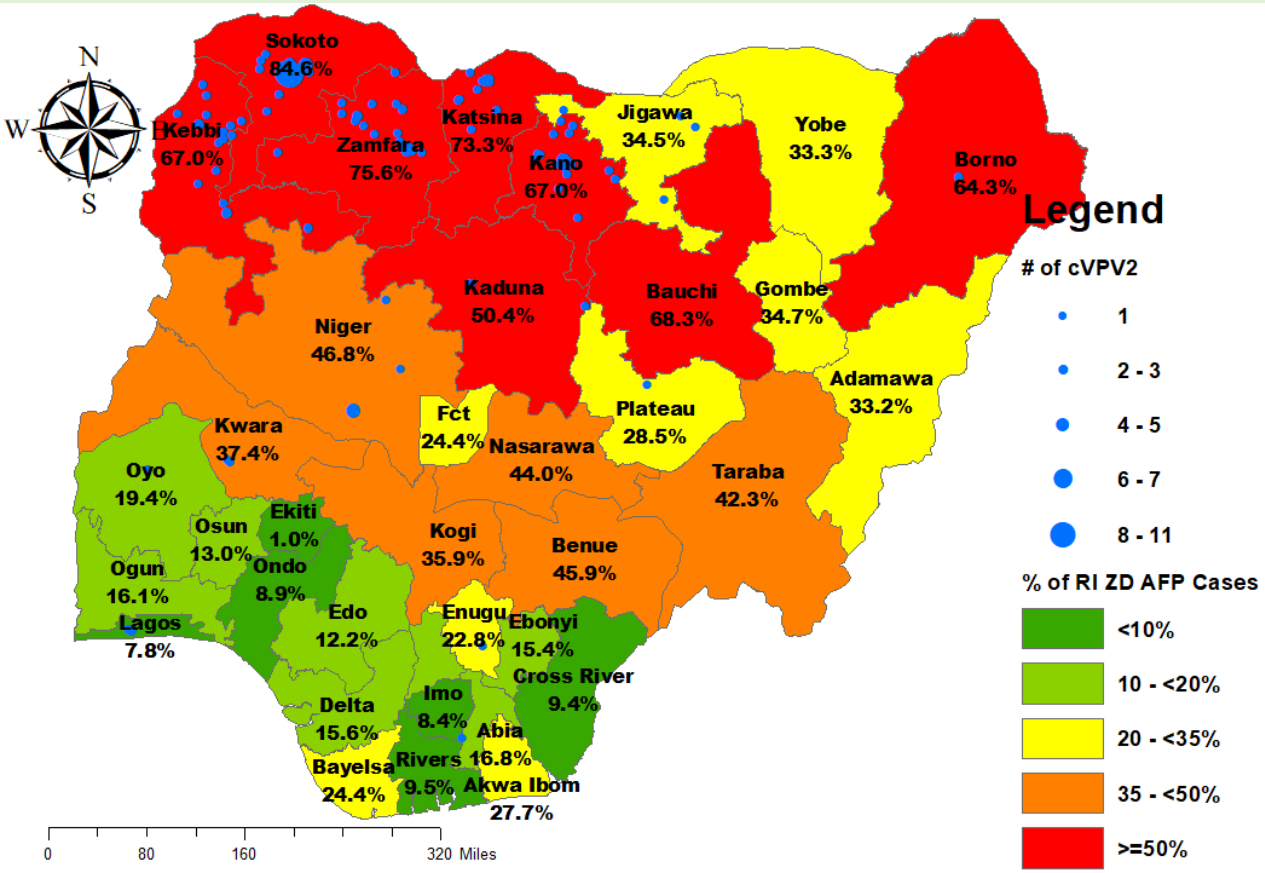
Insights

- Cross River State had the highest routine immunization (RI) coverage (95%) in the NDHS 2023 report when compared with other states.
- Only 13 states plus FCT (40%) had 73% Penta 3 coverage (expected coverage for 2024 as captured in NSIPSS)
- Sokoto, Kebbi and Zamfara had less than 15% coverage in 2023 NDHS report
- Kano, Borno, Sokoto, and Zamfara recorded marginal improvements.

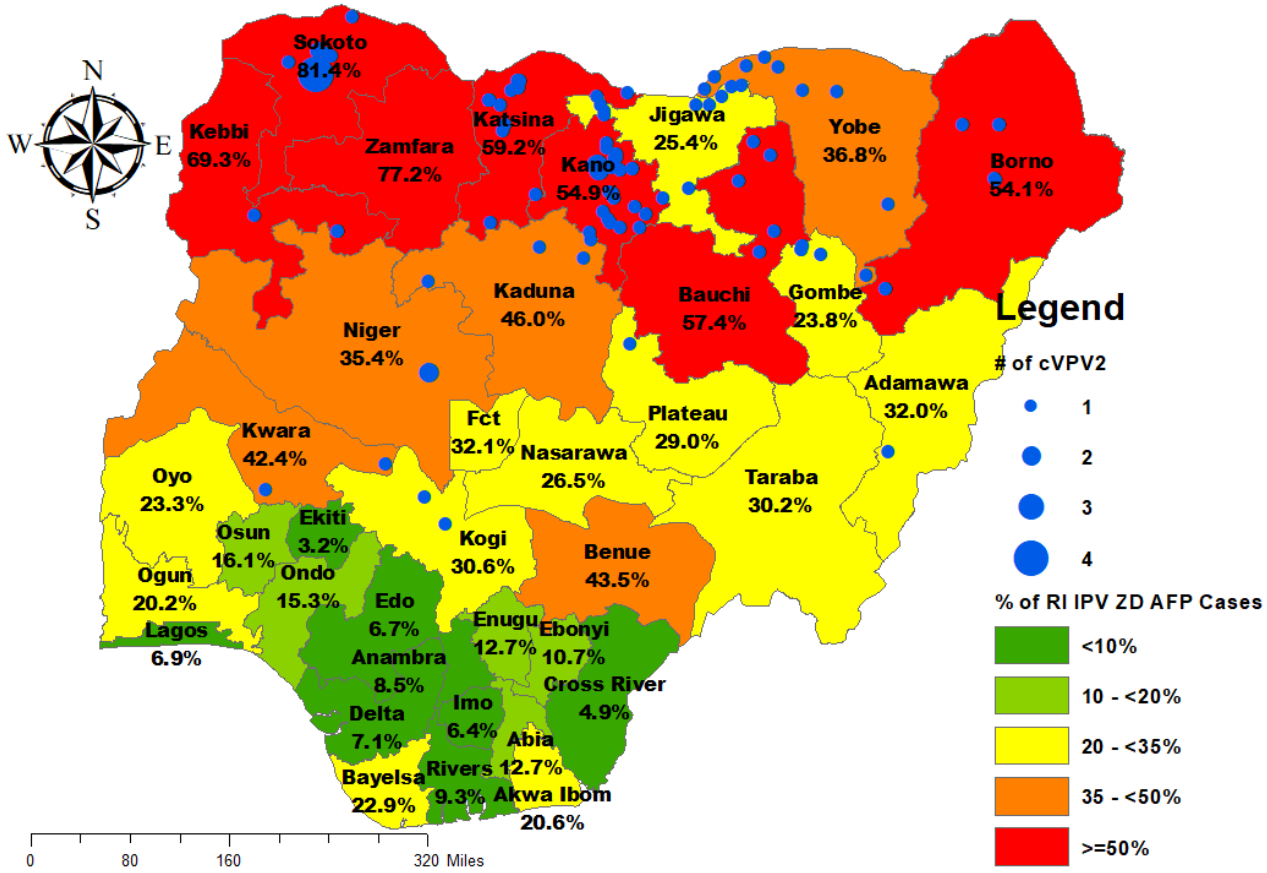
Vaccination Status of AFP cases aged 3-59th Months and distribution of cVPV2s, 2023-2024

cVPV2s are circulating in states with low IPV uptake (Low Immunity)

2023



2024



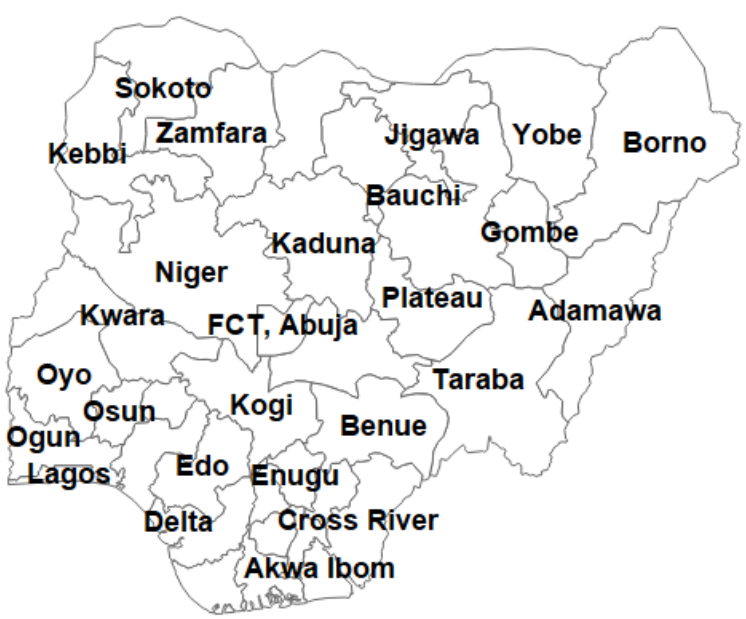
- RI IPV status of AFP cases from Northern states is low and most virus are from same area
- Importance of RI in the control of the spread of the virus
- There is need to intensify IPV uptake in these states to boost type 2 immunity

Source: Team analysis

Map Showing bOPV Rounds Completed by States of Nigeria

All bOPV2 OBR SIAs in the last 12 mos
(May. 2023 - Apr. 2024)

All bOPV2 OBR SIAs in the last 6 mos
(Nov. 2023 - Apr. 2024)



All bOPV2 OBR SIAs in the last 3 mos
(Feb. 2024 - Apr. 2024)

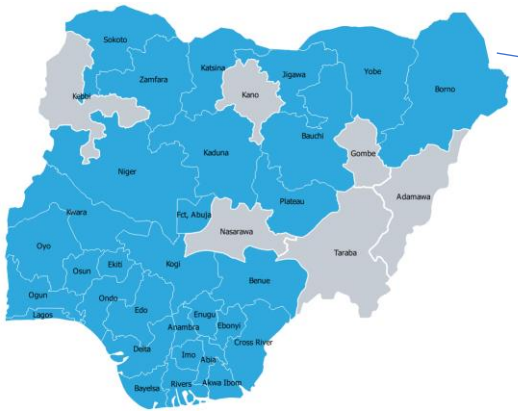
Can we use the opportunity of Fixed Posts during the April & upcoming campaigns to boost population immunity

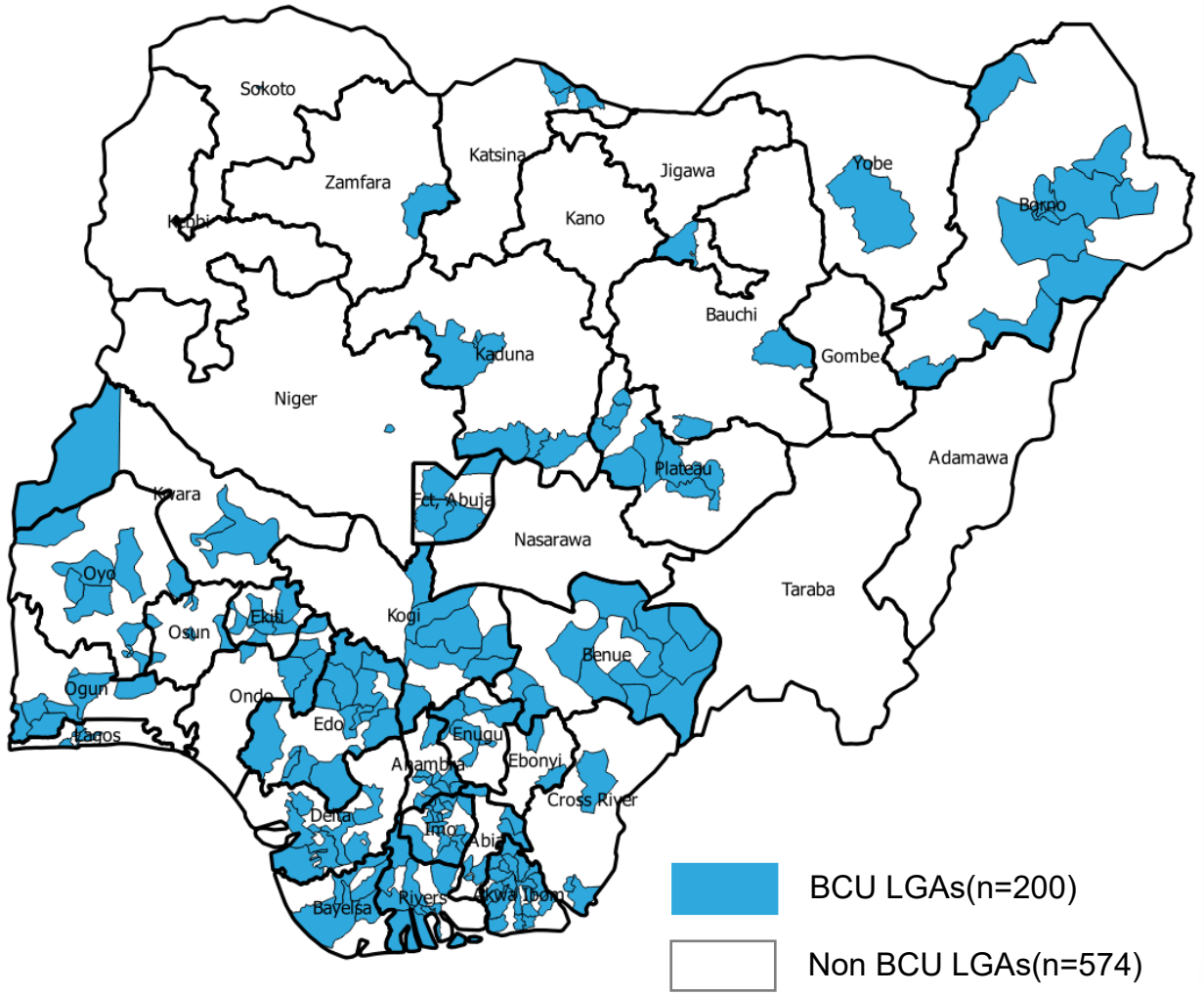
The Country did not conduct bOPV NIDs for over 3 years, this could increase the risk of importation of Types 1 & 3 – VPV3 detection in Afunori ward of Nguru LGA in Yobe State comes to Mind

Prioritized Zero Dose Implementing States

S/N	Name of State	# LGA
1	Bauchi	13
2	Borno	8
3	FCT	1
4	Gombe	4
5	Jigawa	6
6	Kaduna	10
7	Kano	15
8	Katsina	8
9	Kebbi	3
10	Lagos	2

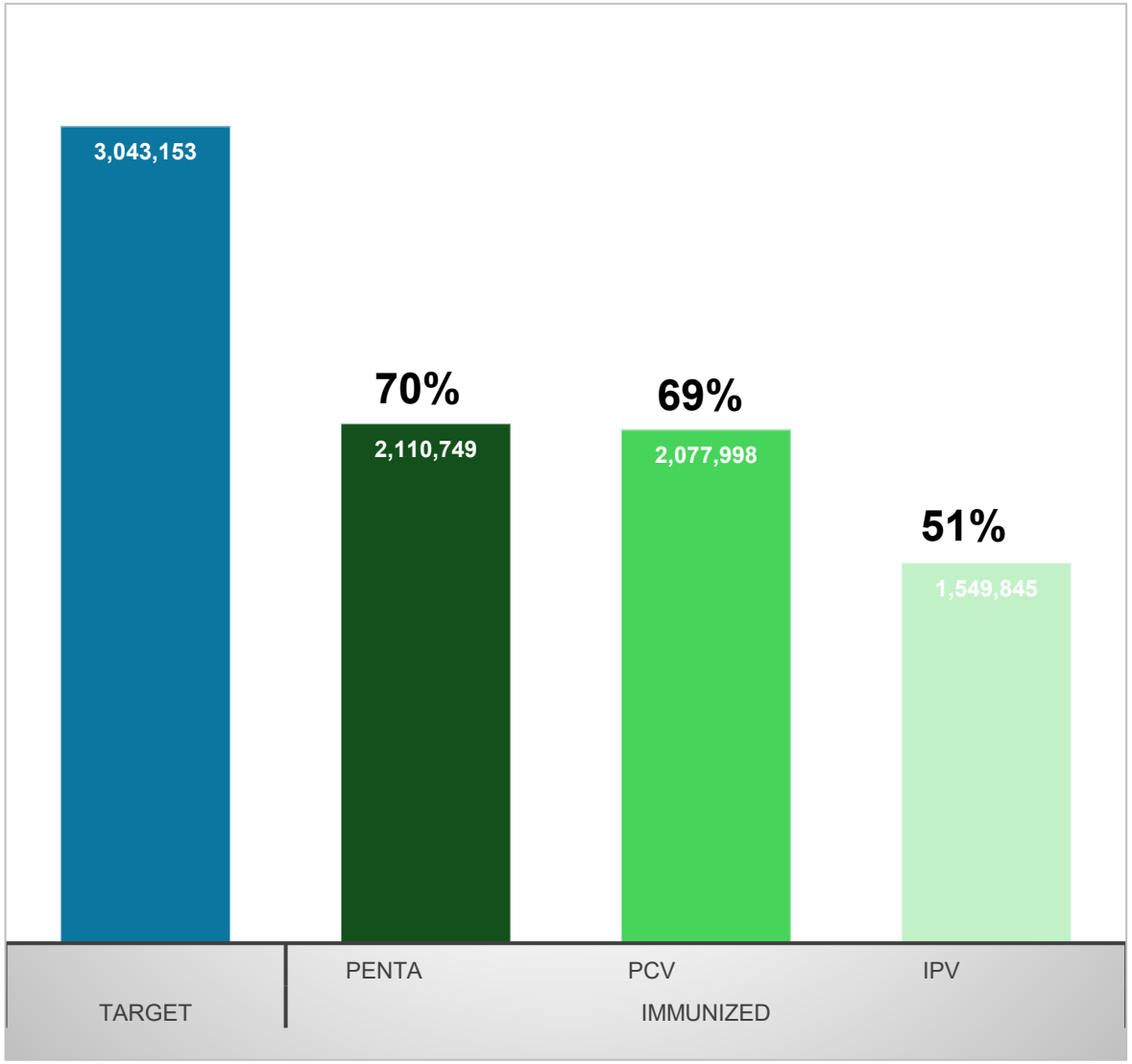
Map showing the 200 Phase 1 BCU Implementing LGAs in 30 states and FCT





SN	State	Number of LGAs
1	Abia	6
2	Akwa Ibom	20
3	Anambra	9
4	Bauchi	2
5	Bayelsa	4
6	Benue	12
7	Borno	10
8	Cross River	3
9	Delta	8
10	Ebonyi	2
11	Edo	14
12	Ekiti	7
13	Enugu	5
14	FCT, Abuja	4
15	Imo	16
16	Jigawa	1
17	Kaduna	6
18	Katsina	3
19	Kogi	7
20	Kwara	3
21	Lagos	5
22	Niger	1
23	Ogun	7
24	Ondo	5
25	Osun	6
26	Oyo	12
27	Plateau	8
28	Rivers	11
29	Sokoto	1
30	Yobe	1
31	Zamfara	1
	Total	**200**

BCU Phase 1: Target Vs Children Reached With Penta, PCV, IPV



- RI intensification implemented during the polio campaign was integrated with IPV

- This affected IPV coverage during BCU where eligibility for every child was checked before administrating the required RI vaccines

Despite the innovations deployed in 2024, challenges still persist – Strategic Shift

We deployed some key innovations in 2024 to tackle the spread of cVPV2 …	… But some challenges continue plaguing the program
Surveillance	**Ward-level sensitivity analysis** to identify silent wards and enhance the quality of surveillance efforts	Increasing number of orphan viruses indicating **silent or undetected transmission** within the population.
SIA campaign quality	Deployment of **e-Tally for OBRs** as a transition from the paper-based tally system**, providing geo- evidence of settlement reach.** **Settlement-based analysis;** triangulating data from multiple sources to **evaluate the quality of vaccination reach,** focusing on metrics such as **time spent in settlements** and the **proportion of settlement areas** covered. Deployment of **AFP Case searchers + NEOC FFM** study to understand the depth and drivers of fake finger marking on the field	High number of non-compliance cases continue to be identified (256,000 unresolved cases in 2024) Interferences in **team selection processes** resulting in the selection of underqualified vaccination team members **High prevalence of Fake finger marking** limiting our ability to measure campaign quality especially in Northern Nigeria
Accountability	Implement the **Accountability Framework** to strengthen oversight, ensure transparency, and enhance the effectiveness of program activities	**Limited awareness** at lower levels, **inadequate use of data** for decision-making, and **political interference** undermine the effectiveness of the Accountability Framework

Source: Team analysis

POB Recommendation-WHY 2025 IS NOT BUSINESS AS USUAL

Conclusion – No More Excuses, Time to Act

POLIO GLOBAL ERADICATION INITIATIVE

This is Nigeria's last opportunity to end polio transmission—good execution must be prioritized.

- Funding is uncertain beyond 2025. If progress is not made in 2025, GPEI may not be in a place to sustain a high level of funding.

The strategy exists. The vaccines are in place.
What's missing is high quality execution, accountability, and urgency.

Now is the time for all partners—government, traditional leaders, and organizations—to fully commit and deliver results.

THANK YOU

Strategic Shift

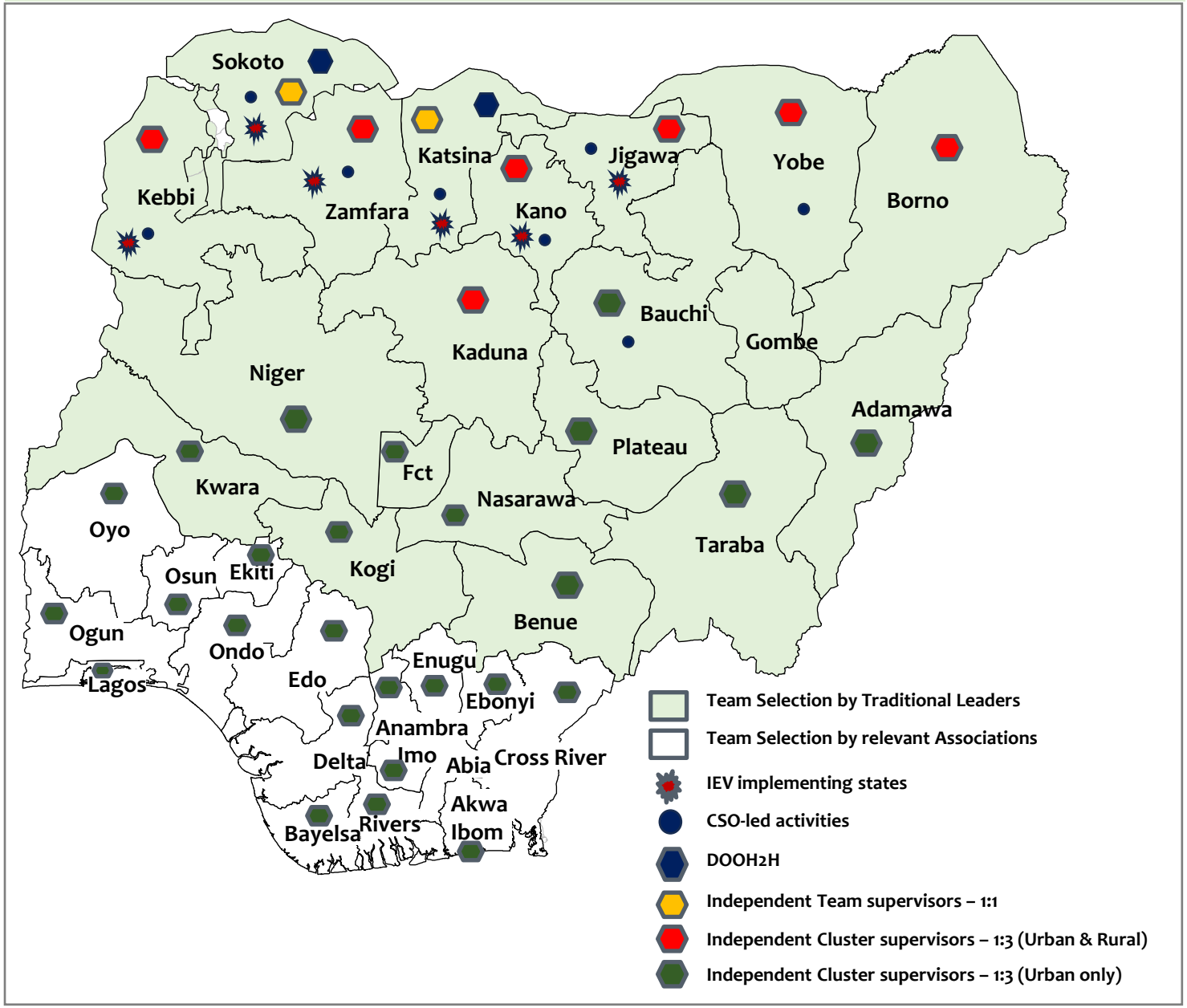
WHO VPDs TA

Overview of the strategic shifts leading up to the April round

Campaign effectiveness pivots	Details	
Independent team selection by external bodies 1	This strategy involves engaging external institutions such as Universities to lead the nomination, selection, engagement, and performance monitoring of campaign personnel	
Directly Observed Outside House-to-House (DOOH2H) vaccination 2	This strategy, set to be piloted in Sokoto and Katsina, aims to enhance vaccination coverage by mobilizing caregivers to bring their children to the front door, where vaccination will be administered outside the household	
Enhanced supervision for sequentially bloc-based April campaign 3	This focuses on engaging and mapping supervisors (National and state personnel, retired nurses, NYSC corpers & school teachers) to SIA teams to provide targeted support during the bloc-based campaign implementation	
Civil Society Organization (CSO)-led demand generation strategy 4	This strategy focuses on leveraging CSOs to raise awareness, drive demand, reduce non-compliance, and eliminate cVPV2 in high-risk polio states through dialogues, edutainment, and targeted NC resolution	
IEV – "One source of truth" for campaign planning 5	The Identify, Enumerate and Vaccinate strategy involves digitally line-listing all eligible children and pregnant women and utilizing the line list to inform vaccination services	
Accountability framework 6	The polio accountability framework is designed to ensure data-driven decision-making at every stage of the campaign. It establishes clear mechanisms for tracking performance, identifying gaps, and driving corrective actions.	

Map of Nigeria showing the spread of activities across states

Map highlighting plans for the April campaigns across the Federation



Scope of implementation of the 2025 strategic shifts

Strategic shift	# states
Team selection by Traditional Leaders	19 + FCT
Team selection by Associations etc.	17
IEV implementing states	6
CSO-led demand generation states	8
Independent team supervisors 1:1	2
Independent Cluster supervisors 1:3 *(Urban & Rural)*	7
Independent Cluster supervisors 1:3 *(Urban only)*	27+FCT

- The accountability framework is cross-cutting and will be tracked across all states.

Content

Revised team selection approach

A. Nomination and Screening

(2 weeks before campaign)

1. State IM tells the Sultan Foundation to start the nomination process.
2. Sultan Foundation works with Emirate Councils to hold meetings with district heads and guide them on selecting candidates.
3. Traditional leaders (Mai Unguwas, Village Heads, District Heads) **nominate and screen** potential team members based on set criteria (with extras as backup).
4. Sultan Foundation collects the final list of screened candidates from district heads.

B. Training and selection

(1 week before campaign)

1. WHO trains the nominated candidates in groups and gives them a test. Candidates must bring passport photos to the training center.
2. The Independent Partner deploy independent observer to selects the final team members based on their performance in training.
3. The CommCare team does biometric verification for all selected trainees at the training venue.
   - If biometric verification doesn't happen at the training, Traditional Leaders (TLs) and an independent observer must be there later to confirm the trainees' identities.
4. The independent observer shares the final list with the district head to confirm that all selected members are from the community. The district head signs off.
5. The independent observer signs off and sends the final, trained and validated list to the State EOC and LGA teams.

C. Deployment & verification

(Intra campaign)

1. LIO, WFP, and partners with oversight from the Independent Partner will create Deployment Implementation Plans (DIPs) using only vaccination team members who were registered on CommCare.
2. Vaccination teams (including replacements) will be chosen only from this trained and approved group.
3. Independent supervisors will check team members in the field using a photo album with their pictures to confirm their identity.

Source: Team analysis

Independent team selection _ Key asks

1. The state to **convene an emergency task force meeting (STFI/STFPHC)** with the LGA chairmen to explain the new team selection process

2. The State Commissioner SMOH/ES SPHCDA/IM to inform LGA Chairmen and all members of the health team (DPHC, LIO & WFP) about the revised team selection protocol. Emphasize how **team selection is now the sole responsibility of the TLs**

3. The state EOC and partners to support the training of the independent selection body after they have been selected

4. Actively supervise the team selection process, resolve emerging issues and flag any deviations from the SOP to the national team

5. Provide feedback to the Political leaders at the May STFI meetings on adherence or not to the SOP

Source: Team analysis 1. Implementing partner

Key next steps and progress on implementing the revised team selection approach

Done | Ongoing | Not due

Focus	Next steps	Timeline	Status	Remark
SOP/training material development	Finalize the revised team selection model plan & develop key next steps with activities & timelines	March 14, 2025	Done	--
	Update the existing team selection SOP to capture the revised team selection model & develop a comprehensive training manual/module to cover the new approach	March 21, 2025	Ongoing	Updated SOP under review
Stakeholder mapping & engagement	Engage the state structure & traditional rulers to secure their buy-in on new approach & assign roles	March 24, 2025	Not due	Strategy team has been assigned to engage different states
	Identify, map & engage the independent entity on revised selection model	March 28, 2025	Not due	A list of possible institutions & organizations have been mapped
Team selection and training	Request for nominations of personnel & screening by selection committee & independent entity	April 15, 2025	Not due	A database of nominees will be developed for ease of tracking
	Conduct training for qualified vaccination team members	April 18-19, 2025	Not due	Buffer provision will be made
	Develop database for successful personnel for proper documentation and subsequent verifications	April 18-19, 2025	Not due	Photobook will be printed for ease of verification
	Conduct final verification of successful candidates to be engaged for the campaign	April 25-29, 2025	Not due	To be done on daily basis throughout the campaign

Source: Team analysis

Content

Directly Observed Outside House-to-House Vaccination

A. Mobilization

(Inside the household)

1. The vaccination team moves systematically through the settlement going house-to-house.
2. The recorder goes into the houses to mobilize the caregivers and bring the children outside to the team.
3. The independent team supervisors move together with the team and observe all the happenings – he's expected to correct the team whenever they deviate from the laid down guidelines and protocols.

B. Vaccination

(Outside the house)

1. The children are vaccinated outside the houses in front of the independent team supervisor.
2. The recorder does the house marking on the houses.

C. Document and issue pluses

(Outside the house)

1. The vaccinated children are recorded on the IEV line list by the recorder.
2. Non-compliance, as well as child absence, are recorded by the recorder on the IEV line list in the Android device.
3. The independent team supervisor documents on the tally the children vaccinated, issues pluses to the caregivers of the vaccinated children, and then tallies on the pluses tally as well.

Source: Team analysis

Content

Team supervision and monitoring

A. Training and Selection of Independent Supervisors (*2 weeks pre campaign*)

1. State EOC contacts institutions (like NYSC, health schools) to find needed personnel.
2. Institutions create a shortlist of potential candidates.
3. An independent partner(e.g., university departments, private research groups) checks if candidates meet the selection criteria.
4. Independent partner/WHO/Other Partners trains the shortlisted candidates at the LGA level.
5. The independent partner selects supervisors based on training performance.
6. Final list of selected supervisors is sent to NEOC and State EOC.

B. Deployment of Independent Supervisors (*1 week pre-campaign*)

1. IM SEOC and Partners creates a deployment plan for Independent Supervisors (IS) and sends it to the LIO, Ward, and State EOC.
2. The plan includes IS team pairings and rotation schedules (Days 1-2 and Days 3-4).
3. The independent partner shares the plan with Independent supervisors and ensures they travel to their assigned LGAs/wards.
4. Deployment varies by state:
   - 1:1 supervision in Sokoto and Katsina
   - 1:3 supervision in Borno, Jigawa, Kano, Kaduna, Kebbi, Yobe, and Zamfara
5. MST provides management support – role is primarily problem solving. (? Checklist)
6. WHO funds IS deployment and **monitors** their activities.

C. Monitoring of Independent Supervisors (*Intra-campaign*)

1. Independent supervisors use ODK checklists to collect data on team performance.
2. Data is uploaded in real-time to a dashboard for monitoring.
3. Any performance issues seen on the dashboard are discussed in evening review meetings using a standard template (Accountability structure)
4. Corrective actions are taken immediately to improve performance during the campaign.

Source: Team analysis

Team supervision and monitoring immediate next steps

The State EOC to map and engage the independent institutions (NYSC, Universities etc). IM to obtain number and names of prospective supervisors from the institutions

---

The State EOC to send collated list of supervisors to Independent party for screening

---

The Independent party with support from WHO to train the selected supervisors and flag deviations from the SOP to National

---

The Independent party with support from SEOC, LGA Team deploy the IS by Team

Source: Team analysis

Action plan – Team Supervision and Monitoring

✓ Done ✗ Not done ⊖ Not due ↻ Ongoing

Theme	Key activities	Status	Timeline	Remarks
Engagement of Relevant Stakeholders	The Operations WG will update SOPs to integrate the revised team supervision model, including supervisor selection criteria and training materials	↻	March 18, 2025	SOPs and training materials to be finalized by Tuesday next week
	The National IM/NEOC to convene a meeting with implementing states to secure buy-in and disseminate implementation SOPs, incorporating state feedback	↻	March 20, 2025	NA
	Implementing states will engage institutions supplying supervisors to confirm personnel availability	↻	March 22, 2025	NA
	The National IM will issue an RFP to IPs[1], requesting the submission of a concept note on supervisor identification and selection in their assigned I&E state	↻	March 24, 2025	NA
Selection and Training	IPs[1], with State OPS WG, will identify, screen, and select supervisors based on set criteria	⊖	April 12, 2025	NA
	IPs[1] with support from WHO will conduct training sessions for the selected supervisors	⊖	April 19, 2025	NA
Deployment and Tracking	IPs[1] and State OPS WG will map and deploy trained supervisors to LGAs, Wards, and vaccination teams	⊖	April 25 – May 1, 2025	NA
	IPs[1], with the State Data Team/WG, will track supervisor performance and provide feedback to parent institutions	⊖	May 8, 2025	NA

1. Implementing Partners
Source: Team analysis

Content

The Civil Society Organizations (CSOs)-led strategy will be implemented to drive demand generation

Overview of the CSO-led strategy

NPHCDA & UNICEF leads the strategy design and works with ACSM implementing partners to drive the engagement of CSOs

ACSM Independent partners (IP) select prioritized LGAs for implementation, identify and select CSOs.
Monitor and track the implementation of the strategy

CSOs are deployed to prioritized LGAs and wards to commence demand generation activities

The CSOs will conduct specific activities to improve ACSM activities:

- ❑ Share information and address misconceptions through community dialogues, compound meetings and sensitization of religious leaders
- ❑ Track and resolve chronic or persistent non compliance by engaging NC households on one-on-one mobilization
- ❑ Track conduct of other social mobilization activities, like jingles, deployment of NCRTs, printing and placement of banners

CSO-led strategy implementation process

	1 CSO mapping	2 Selection and Engagement of CSOs	3 Training of engaged CSOs	4 Deployment of CSOs	5 Monitoring and evaluation
Description	▪ Review and map local CSOs identified based on track record to priority states ▪ Prioritize LGAs and wards based on high burden NC areas and Number of cVPV2	▪ Request for Expression of Interest (EOI) from the CSOs mapped ▪ Institute validation system involving TLs to verify the presence of engaged CSO's	▪ Train on different ACSM and demand generation strategies i.e community dialogue, NC resolution, edutainment, etc	▪ Deploy trained CSOs to commence the demand generation strategies across the wards	▪ Mandate the use of the national tools e.g **ACSM monitoring and NC & CA reporting tool to track the activities** of the CSOs across the deployed wards
Responsible	**Lead:** UNICEF, NPHCDA **Supp:** SCIDaR, CGPP, AFENET	**Lead:** IP **Supp:** UNICEF, SCIDaR, CGPP, AFENET	**Lead:** UNICEF **Supp:** IP, SCIDaR, CGPP, AFENET	**Lead: IP** **Supp:** Unicef, SCIDaR, CGPP, AFENET	**Lead:** NPHCDA, UNICEF **Supp:** IP

Source: Team analysis

CSO-led strategy immediate next steps

State EOC to complete/finalize the mapping of CSOs

The selected Independent partner to **support SHPO/SHE to review the OPERATIONAL plans** in the priority LGA/wards

The state EOC with **support from UNICEF to train CSOs on** their roles

The state EOC to work with selected Independent partner to **deploy the CSOs** in the priority wards

The state EOC to monitor progress and provide routine feedback to national

Source: Team analysis

CSO-led strategy execution plan

Done | Ongoing | Not due

Phase	Next steps	Timeline	Status	Remark
CSO mapping	Strategy WG engages the partners to align on their roles on the strategy	Feb 2, 2025	Done	N/A
	UNIECF finalizes the CSO strategy implementation plan	Feb 13, 2025	Done	N/A
	Pharm Lami briefs the AIT states and Kano on the strategy plan	Feb 15, 2025	Done	N/A
	UNICEF and other partners supports the pilot states to map CSOs existing in the state	Feb 22- March 10, 2025	Done	Done in all the priority states
	UNICEF develops strategy document (training manuals, playbooks, SOPs) and tracking tools	March 16, 2025	Ongoing	The SOPs are currently being developed by the WG
	Government and Implementing partners deployed to pilot states	March 19, 2025	Not due	The NACSM WG will be deployed to the states by next week
Selection of CSOs	Pharm Lami develops call for EOI for CSOs and shares with the IPs for dissemination	March 20, 2025	Ongoing	EOI sent awaiting review and selection
	Implementing partners commences the screening, selection and engagement of CSOs	March 22- April 5, 2025	Not due	Recruitment and selection of CSOs will commence once the EOI goes out
Training and deployment	Implementing partners conduct training of selected CSOs	April 7-9, 2025	Not due	N/A
	IPs deploy CSOs to priority LGAs to commence activities	April 10, 2025	Not due	N/A
Monitoring and evaluation	IPs conducts validation of activities implemented by the CSOs	April 11-25, 2025	Not due	N/A
	Lessons documented and refined as required; scale	May 2, 2025	Not due	N/A

Content

IEV- implementation immediate next steps

Engage LGA authorities to ensure cooperation and **high-quality enumeration process**

Collaborate with the implementing partner and stakeholders to ensure the successful execution of a **high-quality enumeration process**

Expedite the **planning and implementation** to deliver the **finalized database by April 14, 2025**

Oversee the **enumeration exercise** by strategically **mapping state personnel and partners to wards for effective supervision**

Source: Team analysis

Key activities and progress with the IEV enumeration planning in the Phase 1 state

Done Ongoing Not due

Theme	Key activities	Timeline	Status	Remarks
Strategy & milestones	• Develop strategy and milestones in alignment with all stakeholders, learning lessons from the IEV implementation in 2024	*March 14, 2025*		*Some changes were made to the strategy such as the planning processes, enumeration tools, implementation approach etc.*
Partner selection	• Select partners to implement IEV across the priority states • Map partners to states and develop contracts for the selected partners	*March 18, 2025*		*Partners have been selected and mapped to states. Their contracts will be finalized and disseminated in the week of March 17, 2025*
Stakeholder engagement / workplan development	• Engagement of States' ESs and RI team by NPHCDA • Dissemination letters to the states by NPHCDA • Develop implementation workplan collaboratively with the state team	*March 17 – 21, 2025*		*NPHCDA engaged the ESs, RI team and disseminated letters to state. The IPs[1] will conduct additional engagements and develop workplans with the State teams*
Microplanning & team selection	• Develop micro plan and estimate resource requirements • Identify potential sources of key personnel, then screen, select and train competent enumeration team	*March 21 – 26, 2025*		*To ensure that all new settlements are accounted for, settlement validation with traditional leaders will be conducted as a key part of the micro planning process*
Enumeration	• Deploy personnel to conduct enumeration, conduct supervision & monitoring, Implement data quality checks etc.	*April 02 – 13, 2025*		*Data quality checks/analysis such as time spent, duplicate entries, geo spatial spread etc. will be conducted on a daily basis*
Database Finalization	• Compile detailed and validated database of children and pregnant women, then submit final report to the NPHCDA team for review and evaluation	*April 14, 2025*		*The validated database will be submitted to state/national and will be used by all programs for planning and implementation*

Source: Team analysis 1 – Implementing partners

Content

We will leverage the data independently collected pre and intra campaign to drive Accountability

	Pre - campaign *Assessing campaign preparedness (processes and quality)*	**Intra-Campaign** *Driving accountability actions in the areas that most impact effective vaccination delivery*
What data will be collected?	**Assessing processes:** • **Funding:** *Were funds disbursed and received timely by the state, LGA and vaccinators?* • **Logistics (vaccines & pluses):** *Were vaccines and pluses distributed timely to the states and LGAs?* • **Team selection:** *Were teams selected as per the selection protocol?* **Assessing the quality of critical campaign dependencies:** • **Microplan readiness:** *Does the microplans have all the key details e.g (All settlements from the MLOS, high risk settlements, special places* • **Training:** *Were quality trainings conducted at ward level ?* • **ACSM:** *Were all ACSM activities executed?*	• **Vaccine mismanagement:** *Did teams waste vaccines on the field? (e.g. pouring vaccines away or other mismanagement activities)* • **Fake-finger marking:** *Were teams involved in fake finger making practices?* • **Data falsification:** *Were teams involved in over-tallying/data fraud?* • **Team performance:** *Were teams able to translate basic knowledge acquired on the field?*
By who?	**Independent evaluators deployed by Acasus**	**NEOC independent supervisors**
When?	Starting 3 weeks before campaign	**All** through the campaign - 6 days
How will the data be used?	**During EOC meetings** at State and National levels for action **Presented to NEOC Strategy Group and ED-NPHCDA** for decision making	**During Evening Review meetings** at LGA, State and National levels - *Key decisions to address gaps and accountability measures are implemented*

Accountability key deliverable tracker

Completed
In progress
Not due

Activity	Deadline	Status
Finalize scope and approach with key stakeholders	24 Mar	
Identify pool of data collectors across states	24 Mar	
Finalize training materials	28 Mar	
Conduct training and engagement of data collectors	Apr 5	
Finalize pre and intra campaign checklist	28 Mar	
Finalize dashboard development/refinement	4 Apr	
Orient key stakeholders partners, SEOC, LGA chairmen	4 Apr	

THANK YOU

Vaccination Strategies

SIO

Outline

- Polio Vaccination strategies per State
- Team Roles and Responsibilities
- Door-to-Door Vaccination Process
- Process of Vaccination Outside Households by Transit Team Members During Polio Campaigns
- Things to Avoid during Polio Vaccination Campaigns
- Simulation and Role-Playing

Polio Vaccination Strategies per State

DOH2H (after IE)	1 Vaccinator 1 Recorder/ team supervisor 1 Community leader 1 Independent team supervisor	Sokoto, Katsina
DOPV teams	1 Vaccinator. 1 Recorder.1 Recorder	Kebbi, zamfara, Kano, Yobe, Jigawa, Bauchi, Gombe, Adamawa, Taraba, Kaduna,Borno, FCT
H2H teams (after IE)	1 Vaccinator. 1 Recorder 1 Community leader (An Independent Cluster supervisor is attached to at least 3 Teams)	Borno, Kaduna,Kebbi, Zamfara, Kano, Jigawa and Yobe
H2H teams (after mini microplanning)	1 Vaccinator. 1 Recorder 1 Community leader	All States except Sokoto, Katsina, Borno, Kaduna, Kebbi, Zamfara, Kano, Jigawa and Yobe
Fixed post teams	1 Vaccinator. 1 Recorder	All States
Transit/special teams	1 Vaccinator. 1 Recorder. 1 Town announcer	All States

Team Roles and Responsibilities---1

- **Vaccinator**
  - Engage with households to explain the purpose of the visit
  - Address any concerns or hesitations about vaccination
  - Undertakes finger marking on the left little finger
  - Ensure proper storage and handling of vaccines
  - Report adverse events following immunization (AEFI).
- **Recorder:**
  - Undertakes Tallying of Children Vaccinated
  - Perform house marking after vaccination is completed (Not applicable to vaccinations done outside households)
  - Send the E tally data at the completion of work n each settlement

Team Roles and Responsibilities---2

Community Leader:

- Act as a liaison between the team and the community and inform the community a day before the team's arrival, and pre-mobilize the household during implementation.
- Address vaccine hesitancy or non-compliance through dialogue, community trust, and other appropriate approaches.
- Reports unresolved noncompliance to the next hierarchy of traditional/ religious leadership.
- Resolve disputes or concerns raised by caregivers.
- Participate in revisiting households with absent children and vaccinate them.
- Ensures that all households in a settlement are visited by the team and all eligible children in the community are vaccinated.

Team Roles and Responsibilities---3

Independent Cluster Supervisors – (Some selected States in the South)

Meet with assigned teams at the take-off point every morning and attend early morning refresher training

- Cross-check on the DIP & Community Leader if they are in the right settlement
- Observe the administration of OPV drops to ensure compliance with protocols
- Ensure the vaccinator marks the child's finger after vaccination
- Confirm with the Community Leader & Team supervisor that all households have been visited before moving to the next settlement (as appropriate)
- Counter sign on the tally sheet as confirmation of completion before moving to the next settlement
- Attend ward-level ERM

Door-to-Door Vaccination Process -1

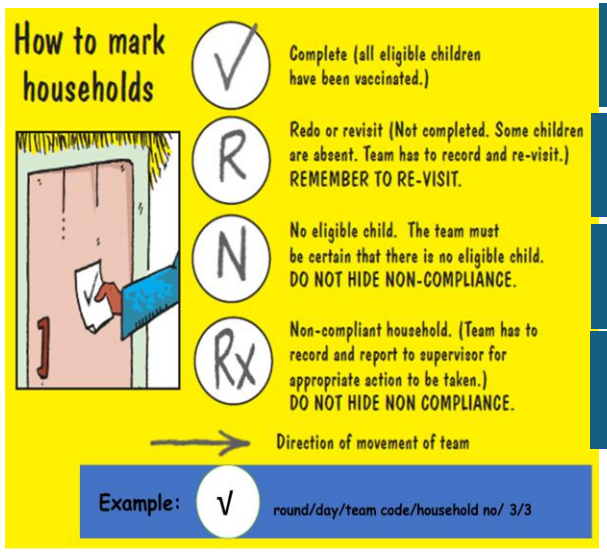
Household Approach

- The Vaccinator introduces the team and explains the purpose of the visit.
- The Recorder/Vaccinator asks the 6 Key questions to ensure the completeness of all the eligible children in the households (including visitors)
- The Community leader intervenes where there is hesistancy/noncompliance
- The Vaccinator administers the vaccine to eligible children seen in the household and ask for when to meet absent children in the household
- The Recorder Tallies the children vaccinated
- The recorder writes the details of children absent in the household
- The recorder undertakes the applicable house marking
- The Independent Team supervisor verifies the data and ensures accuracy and tallies on the hard copy Tally sheet

House-to-House Vaccination Process -2

House marking

- The Recorder marks the household after vaccination is completed to indicate that the visit was successful



NIPDS-April 2025/YEN/DAY1/001/001/3/3

NIPDS-April 2025/YEN/DAY1/001/001/3/2

NIPDS-April 2025/YEN/DAY1/001/001/0/0

NIPDS-April 2025/YEN/DAY1/001/001/3/0

Campaign Round/LGA/Day/Team Code/Household/Children Vaccinated

Revisit

- The Team schedule return visits for any missed vaccinations or follow-up doses

Process of Vaccination Outside Households by Transit Team Members During Polio Campaigns ---1

Objective:

- To ensure all eligible children (typically under 5 years) are vaccinated against polio, including those encountered outside households (e.g., in transit, markets, public places, or temporary settlements).

Team Composition:

- **Transit Team Members:** Typically 3 trained members (Vaccinator/Vaccinator/Town announcer with a megaphone) equipped with vaccine carriers, finger markers, tally sheets, and ice packs.

Supervision: Supervisors vist teams for monitoring and support.

Process of Vaccination Outside Households by Transit Team Members During Polio Campaigns ---2

1. Pre-Campaign Preparation

- **Training:** Team members are trained on vaccination techniques, cold chain management, and recording.
- **Mapping Transit Points:** Identify high-traffic areas (markets, bus stops, railway stations, parks, nomadic settlements, etc.).
- **Logistics:** Ensure vaccine carriers, ice packs, finger markers, and data tools are ready.

2. Team Deployment

- **Route Planning:** Assign transit points based on population movement patterns.
- **Timing:** Focus on peak hours (e.g., early morning markets, school hours and closing times, Church services and closing times)

Process of Vaccination Outside Households by Transit Team Members During Polio Campaigns ---3

Vaccination Process in Transit

- **Approach & Screening:**
  - Politely approach caregivers (parents, guardians) to check if the child is under 5.
  - Ask if the child has already been vaccinated in the campaign (check finger marking).
- **Administering Drops:**
  - If unvaccinated, provide **2 drops of Oral Polio Vaccine (OPV)**
  - Mark the child's left little finger with indelible ink.
- **Record Keeping:**
  - Tally each vaccinated child by age (e.g., <1 year, 1-5 years).
  - Note refusal cases (if any) for follow-up.

Key notes:

✓ **Cold Chain Maintenance:** Ensure vaccines remain at 2–8°C.

✓ **Gentle Communication:** Build trust with caregivers.

✓ **Zero-Miss Approach:** Strive to vaccinate every eligible child.

Process of Vaccination Outside Households by Transit Team Members During Polio Campaigns ---4

Special Situations

- **Mobile Populations:** Cover migrant families, travelers, or temporary settlements.
- **Refusals:** Politely educate caregivers; escalate to social mobilizers if needed.
- **Missed Children:** Inform fixed teams or nearby health centers for follow-up.

End-of-Day Reporting

- Submit e-tally before returning from the field
- Submit tally sheets to Ward Focal Persons.
- Ensure vaccine carriers are cleaned and stored properly for the next day

Monitoring & Supervision

Supervisors conduct random checks to ensure

1. compliance.
2. Address challenges (e.g, vaccine shortages, community resistance).

Fixed Post Vaccinations – Key notes

- Engage trained health workers only
- Select locations from Health Facility register using fixed Post selection matrix
- Ensure all antigens are available
- Always use immunization register for recording RI antigens and Tally sheets for Polio Vaccination
- Pre-mobilize communities
- Use banners, signs, and flags to attract caregivers and Ensure shade, seating, and a clean, child-friendly space
- Keep vaccines at 2–8°C in a functional vaccine carrier.
- Safely dispose of used vaccine vials and cotton swabs
- Fixed Posts must be supervised

Things to Avoid during Polio Vaccination Campaigns---1

1. Avoid Poor Preparation

❌ **Not checking supplies** (vaccines, finger markers, tally sheets, ice packs).
❌ **Ignoring cold chain protocols** (letting vaccines get too warm or freeze).
❌ **Starting late**—delays reduce the number of children reached.

2. Avoid Unprofessional Behavior

❌ **Being rude or impatient** with caregivers—always be polite and respectful.
❌ **Dressing inappropriately**—wear campaign Tags and aprons for credibility.
❌ **Using aggressive persuasion tactics**—instead, educate gently on polio risks.

3. Avoid Skipping Houses or Children

❌ **Assuming a house is empty** without knocking or checking.
❌ **Not asking about all eligible children** (e.g., missing newborns or visitors).
❌ **Skipping areas** (slums, remote homes, or households with refusals).

Things to Avoid during Polio Vaccination Campaigns---2

4. Avoid Poor Record-Keeping

- ❌ **Not marking fingers**—leads to duplicate vaccinations or missed children.
- ❌ **Filling tally sheets incorrectly**—inaccurate data affects campaign success.
- ❌ **Forgetting to report noncompliance**—supervisors need this for follow-up.

5. Avoid Hygiene & Safety Lapses

- ❌ **Not sanitizing hands** before administering vaccines.
- ❌ **Using expired or contaminated vaccines**—always check vials.
- ❌ **Leaving vaccine carriers open** (exposing them to heat or sunlight).

6. Avoid Ignoring Community Concerns

- ❌ **Dismissing rumors or fears**—address them with facts, not arguments.
- ❌ **Working alone in high-risk areas**—prioritize safety in insecure zones.
- ❌ **Not involving local leaders**—community support improves acceptance.

7. Avoid Wasting Time

- ❌ **Long unnecessary breaks**—stick to the schedule.
- ❌ **Getting distracted (e.g., phone overuse)**—focus on vaccination targets.
- ❌ **Revisiting the same houses multiple times**—plan routes efficiently.

Pictorials for Simulation

Questions and reminders for vaccinators

1) How many children less than 5 years of age, including newborns and sleeping children, do you have in this household?

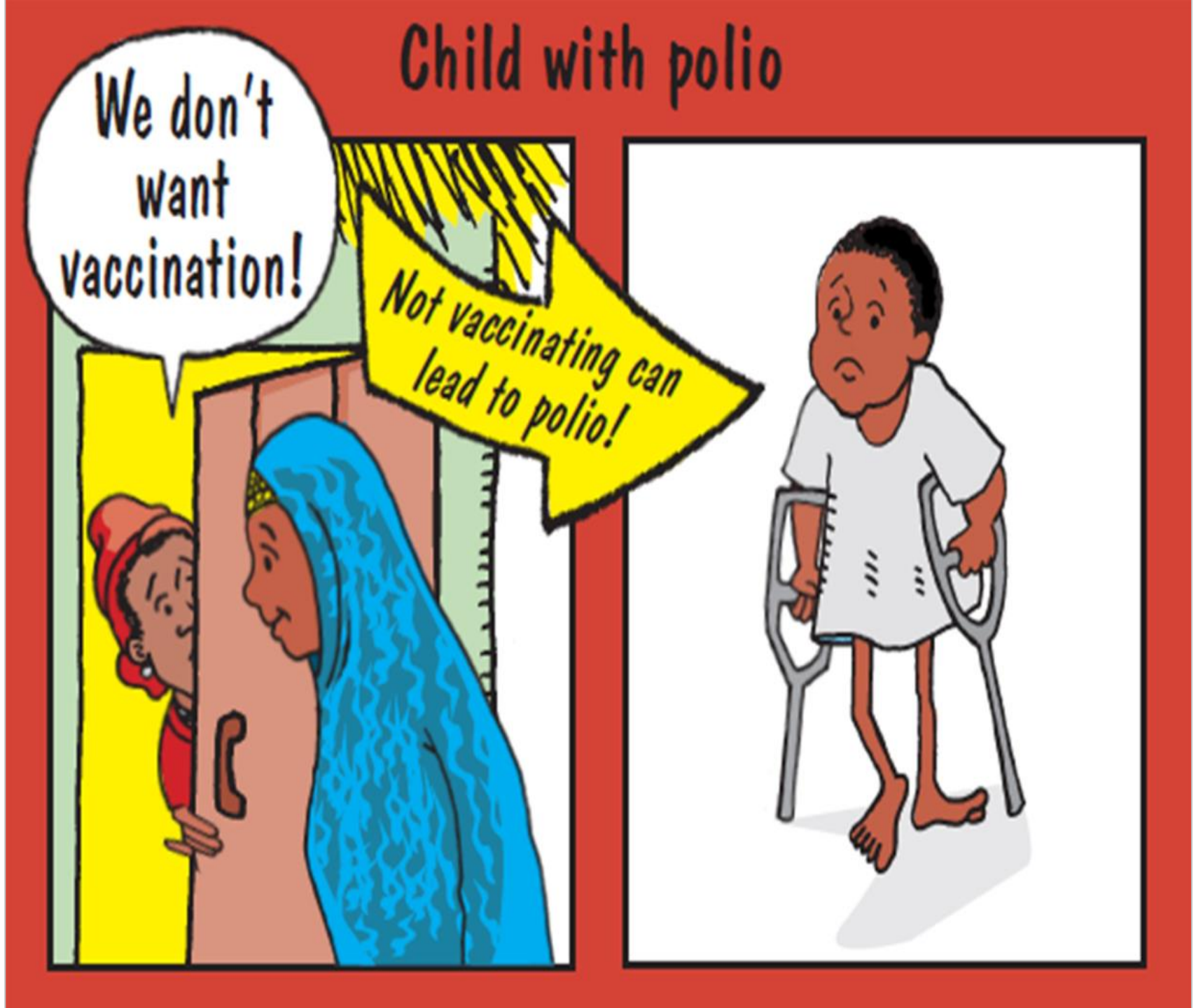
2) Are there any children less than 5 years of age in this household who have visited from other places?

3) Are there any children less than 5 year who are absent now?

4) Have you heard about any child with weakness within this community?

5) Remember to go to the nearest health centre for other immunizations

6) The next campaign will be on the following dates:


Child with polio
We don't want vaccination!
Not vaccinating can lead to polio!

Receiving vaccine drops

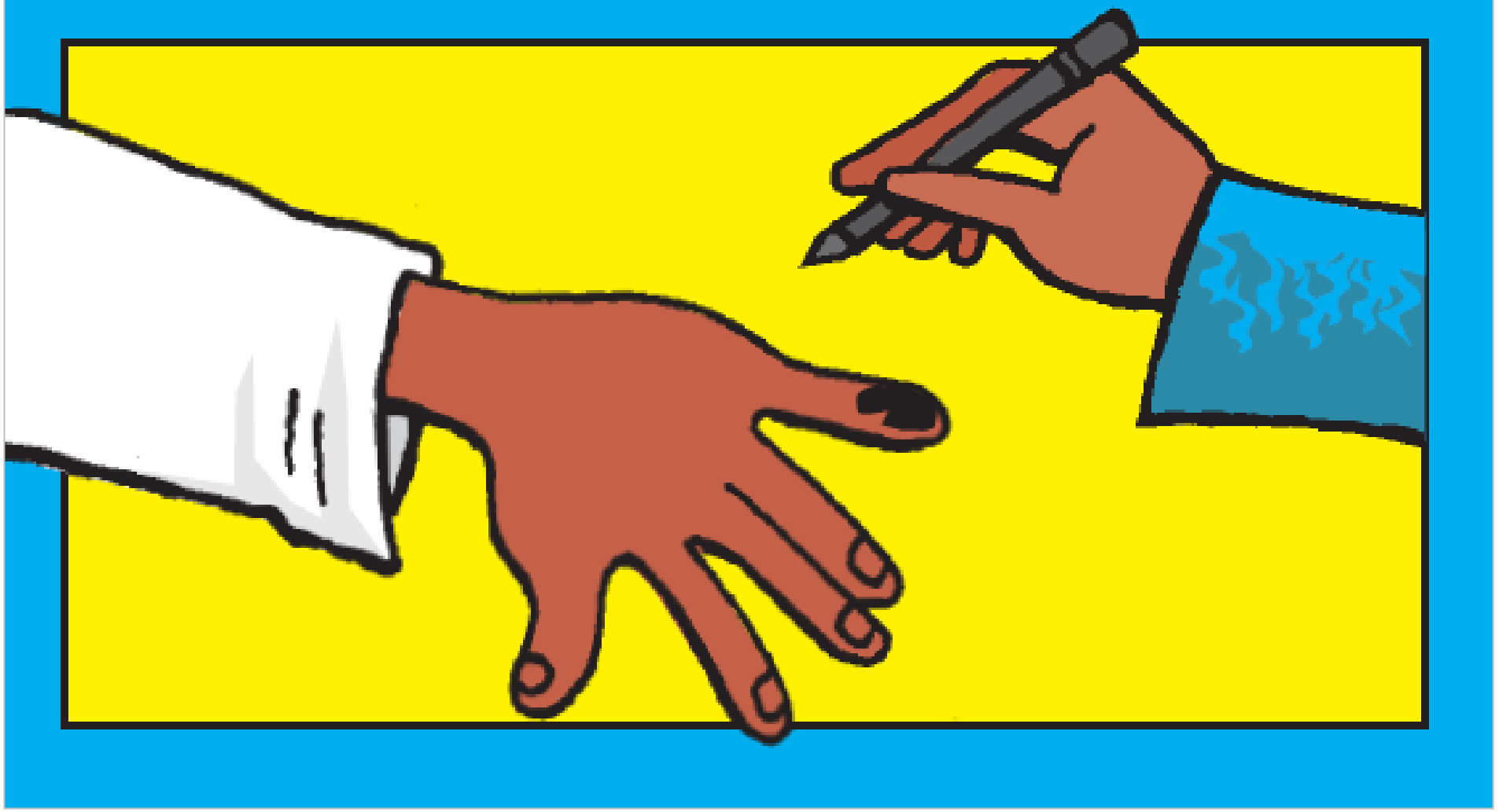
How to administer drops:

The dropper should not touch the mouth of the child.

The drops should fall on the tongue

Finger Marking

Mark left litle finger including skin above the nail.



Make sure to mark tally sheet

Name and address of first household owner with landmarks:

Household number	1	2	3	4	5	6	7	8	9	10	Total	Total
Total number of under 5 children in household	2	3	2	1	4	1	3	3	1	2	22	
Number of under 5 children immunized	2	0	2	1	4	0	1	2	1	2		15
Household number	11	12	13	14	15	16	17	18	19	20		
Total number of under 5 children in household												
Number of under 5 children immunized												

Total	Total Households Visited							Total Children				
Number of children immunize on streets, motor parks, schools, water points, social events, playgrounds etc. Mark a tally "/" for each child immunized & encircled the sites visited)	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	ϕϕϕϕϕ	16
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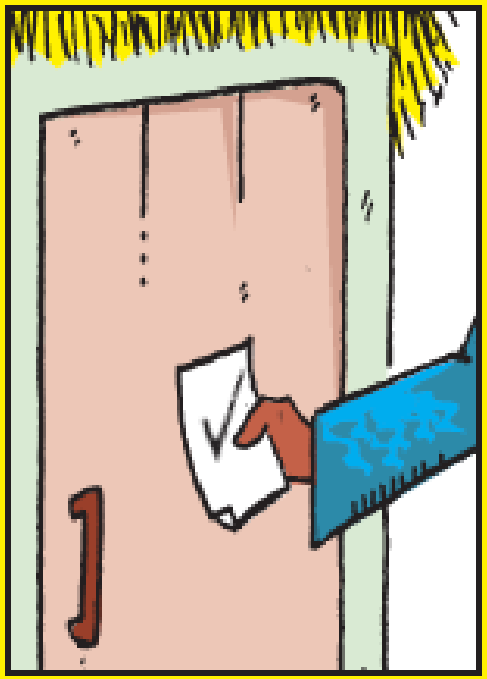
How to mark households



√ Complete (all eligible children have been vaccinated.)

R Redo or revisit (Not completed. Some children are absent. Team has to record and re-visit.)
REMEMBER TO RE-VISIT.

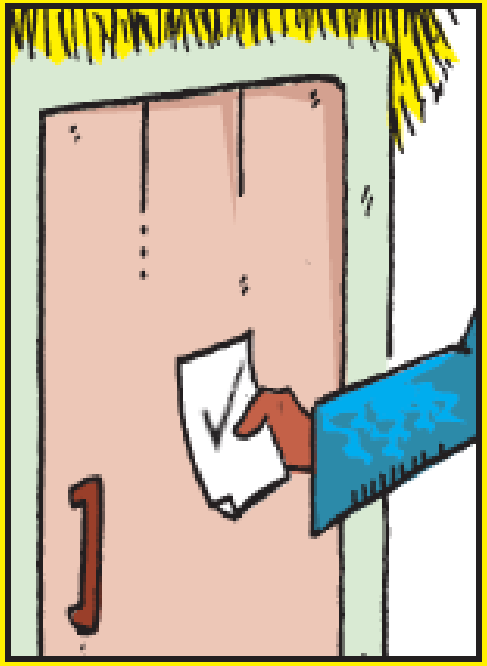
N No eligible child. The team must be certain that there is no eligible child.
DO NOT HIDE NON-COMPLIANCE.

Rx Non-compliant household. (Team has to record and report to supervisor for appropriate action to be taken.)
DO NOT HIDE NON COMPLIANCE.

→ Direction of movement of team

Example: √ round/day/team code/household No/ #/#

How to mark households



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DO NOT HIDE NON-COMPLIANCE.

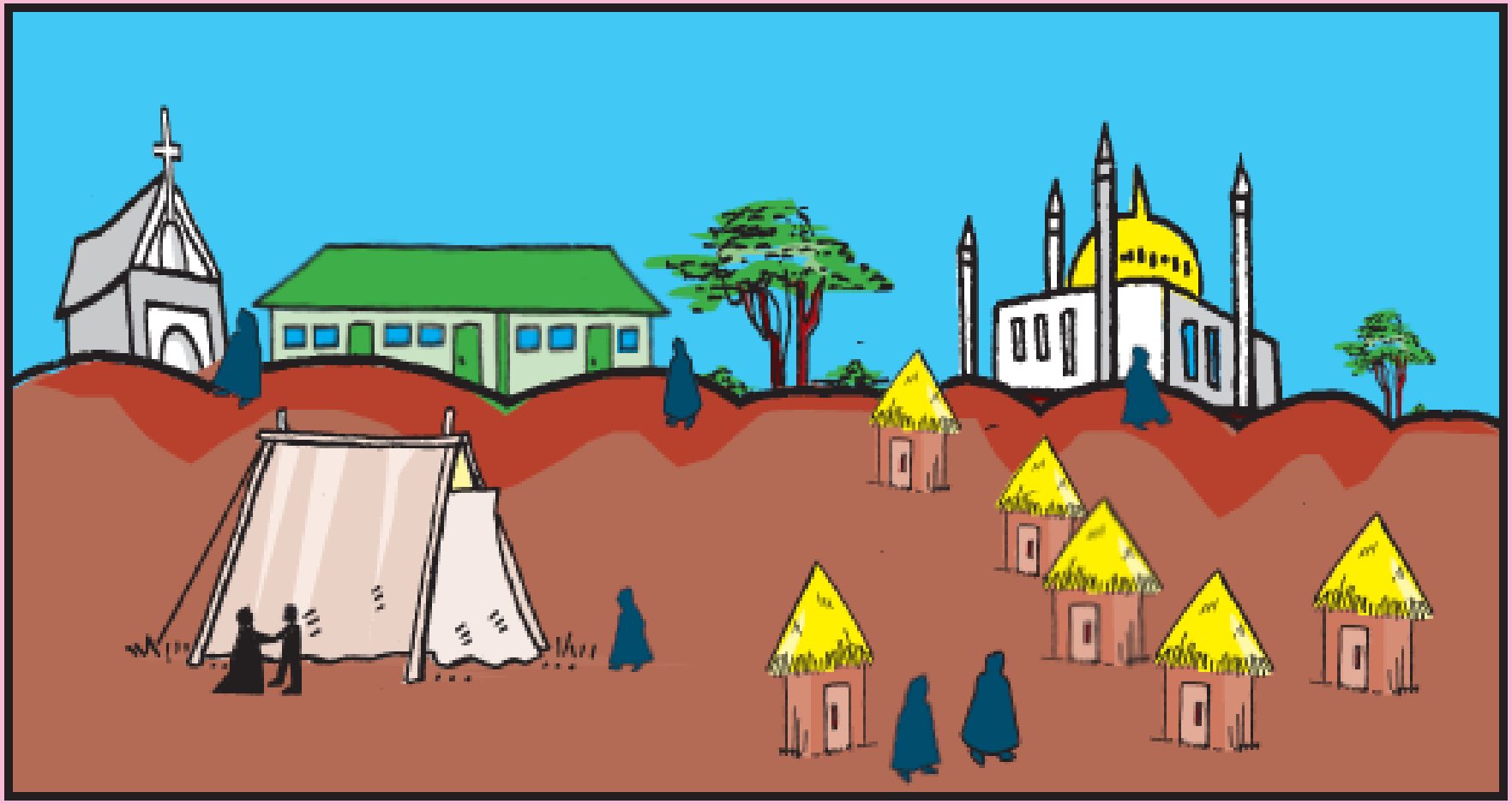
Rx Non-compliant household. (Team has to record and report to supervisor for appropriate action to be taken.)
DO NOT HIDE NON COMPLIANCE.

→ Direction of movement of team

Example: √ round/day/team code/household no/ 3/3

Other places to look for children

Streets, Markets, Water Points, Playgrounds, Ceremonies, Farms, Mosques, Schools, Homes, Churches



THANK YOU

Discussions

ALL

Quality Training for SIAs

WHO APHO

Outline

1. High-Quality Training & Why It Is Important?
2. Training Category & Classification
3. What Makes Training of High-Quality?
4. Quick Guide on the Training Approach
4. Additional Tips on Achieving High-Quality Training

Source: Team analysis

Ensuring High-Quality Training for Polio Campaigns

Objectives

1. Equip trainers with updated knowledge and skills
2. Ensure consistency & effectiveness in training delivery
3. Improve team performance & campaign outcomes

What is a high-quality training session and why is it important???

What is a high-quality training and why is it important?

Definition

- A well-structured and engaging training that equips participants with the necessary **knowledge**, **skills**, and **confidence** to perform their roles effectively
- It is structured, **engaging**, and **tailored** to the learners' needs, ensuring long-term retention and practical application

Key Characteristics

- Practical & Hands-on
- Interactive & engaging
- Tailored to learners' needs
- Uses effective training methods
- Ensures knowledge retention

Importance

- **Improves Performance** – Enhances efficiency and accuracy in task execution
- **Enhances Knowledge Retention** – Encourages long-term learning and application
- **Boosts Confidence & Motivation** – Empowers trainees to apply skills effectively
- **Ensures Standardization** – Aligns teams with campaign strategies for consistency
- **Increases Campaign Success** – Leads to better execution, higher coverage, and improved health outcomes

SOURCE: Team analysis

Training Category & Classification (1/2)

Focus areas	Vaccinators	Community Leaders	Recorders	Independent Team Supervisors	Independent Cluster Supervisors
Level of Training	▪ Ward	▪ Ward	▪ Ward	▪ Ward/LGA	▪ Ward/LGA
Materials required	▪ One-pager guide (hard copy) ▪ Post-test questions	▪ One-pager guide (hard copy)	▪ Training manual ▪ Tally sheet ▪ One-pager guide (hard copy) ▪ Android phones ▪ Pre & Post test	▪ Training manual (soft copy) ▪ One-pager guide (soft) ▪ Android phones ▪ Pre & post test	▪ Training manual (soft copy) ▪ One-pager guide (soft) ▪ Android phones ▪ Pre & post test
Must Do	▪ Role plays, demonstrations & hands-on, IPC	▪ Role plays & simulations, IPC	▪ Role plays, demonstration, hands-on, IPC	▪ Hands-on, demonstration, IPC skills	▪ Hands-on, demonstration, IPC skills
Trainer	▪ WHO (Lead) ▪ Other partners ▪ WFP	▪ WHO (Lead) ▪ Other partners ▪ WFP	▪ WHO (Lead) ▪ Other partners ▪ WFP	▪ WHO (Lead) ▪ Other partners	▪ WHO (Lead) ▪ Other partners
Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist

Training Category & Classification (1/2)

Focus areas	Ward Focal Person	LGA Team	State Team	Senior Supervisors	MSTs
Level of Training	▪ LGA	▪ LGA/State	▪ State	▪ State	▪ National
Materials required	▪ Training manual ▪ Microplan & Reporting templates ▪ Post-test questions	▪ Training manual ▪ Reporting checklists & templates ▪ Pre & post tests	▪ Training manual ▪ Reporting checklists & templates ▪ Pre & post tests	▪ Training manual ▪ Reporting checklists & templates ▪ Pre & post tests	▪ Training manual ▪ Reporting checklists ▪ Pre & post test
Must Do	▪ Demonstrations, Hands-on ▪ Use Projector	▪ In-person training ▪ Use projector ▪ Demonstrations	▪ In-person training ▪ Use projector ▪ Demonstrations	▪ Hybrid training ▪ Use projector ▪ Demonstrations	▪ Hybrid training ▪ Use projector ▪ Demonstrations
Trainer	▪ State Team & Partners	▪ State Team & Partners	▪ State Team & Partners	▪ State Team & Partners	▪ NEOC & Partners
Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist	▪ IPDs_Training Checklist

What makes a training of high-quality? (1/2)

Focus Areas	Description	
1 **Training Needs Assessment**	▪ Identifying their knowledge/skills gaps & **learn from previous** rounds ▪ Focus on **key subjects** – vaccine admin, finger marking, IPC skills, VVM ▪ **Integrate new strategies** to address evolving issues	
2 **Trainer Selection & Capacity Building**	▪ Criteria for selecting Trainers – ▪ National, State & LGA level Govt or Partner personnel ▪ Trainer must **understand the subject** & **new strategies** ▪ Engaging & can effectively transfer knowledge	
3 **Standardized Training Materials & Methods**	▪ Manuals, **job aids** (one-pager printout) and digital tools to be utilized ▪ **Adult learning** principles must be adopted – interactive sessions ▪ Consistency across all levels in training	
4 **Effective Training Delivery Approaches**	▪ Engaging methods – **Role plays**, group discussions, case studies ▪ **Blended learning** that involves In-person + digital + on-the-job method ▪ Practical application through **demonstrations** & simulations	

What makes a training of high-quality? (2/2)

Focus Areas	Description

5 **Monitoring & Evaluation of Training Effectiveness**	▪ Assessment techniques:
	  ▪ **Pre- and post-test** knowledge tests (as it applies)
	  ▪ Cut-off for Post-test **>=70%**
	  ▪ Field assessment (supervision by MSTs) & Feedback to teams

6 **Sustainability & Continuous Learning**	▪ **Refresher training** must be instituted ▪ Digital platforms (e.g. virtual links) for ongoing learning ▪ Deploying short videos
7 **Training guide for independent training monitors**	▪ Training to be supervised by **Independent observer (Partners)** ▪ A **guide** to be used by independent monitors deployed to evaluate the quality of trainings being conducted for campaign workers
8 **Personnel, Training Outcome & Timeline**	▪ Train a larger pool than required & pick only those who **pass post-test** ▪ Personnel should be chosen based on revised selection guidelines ▪ Training should be concluded **one-week** (**7 days**) to campaign

Hall capacity: not more than 40 people per class for ward-level trainings

Quick Guide on the Training Approach

Focus	State	LGA	Ward
Description	Conduct of STOT (State training of trainers) : Training of DPHCs, LIOs, STFs, RIOs, LHEs, LCCOs, M&Es, DSNOs, LGAFs + partners	Training of WFPs, Team, VAOs, FVs, VWSs and Village head	Training of Team members selected by Traditional Leaders & verified by Independent Observer
Who trains?	State team and Partners	LGA teams and partners	WHO + other partners
Who will monitor training?	ES SPHCDA , NPHCDA ZTO and SCs, NEOC members, and Partners	ES SPHCDA , NPHCDA ZTO and SCs, NEOC members, State and LGA team and partners, DPHCs, District head	DPHCs, District head, State and LGA team and partners, Community leaders, Traditional Leaders (Village head and Mai'Unguwas)
	Independent Observers will be deployed for the evaluation of the selection & training exercise across all levels (partners) ***All trainings should be monitored using ODK checklist that also captures attendance list and action pictures, etc.***		
Recommended topics to be covered	▪ Recommended Topics to be covered – cVPV2 cases & implications; New vaccination strategy (DOH2H, ITS, ICS, etc); Conducting quality microplanning; – Institutionalization of accountability frame work – Vaccine handling & management; IPC skills for effective engagement of caregivers – Effective supportive supervision, etc		

Additional tips on achieving a high-quality training session

Arrive the venue on time

Start early to maximize learning

Consider break time for prayers

Ensure the availability of training materials

Ensure the availability of smartphones with participants

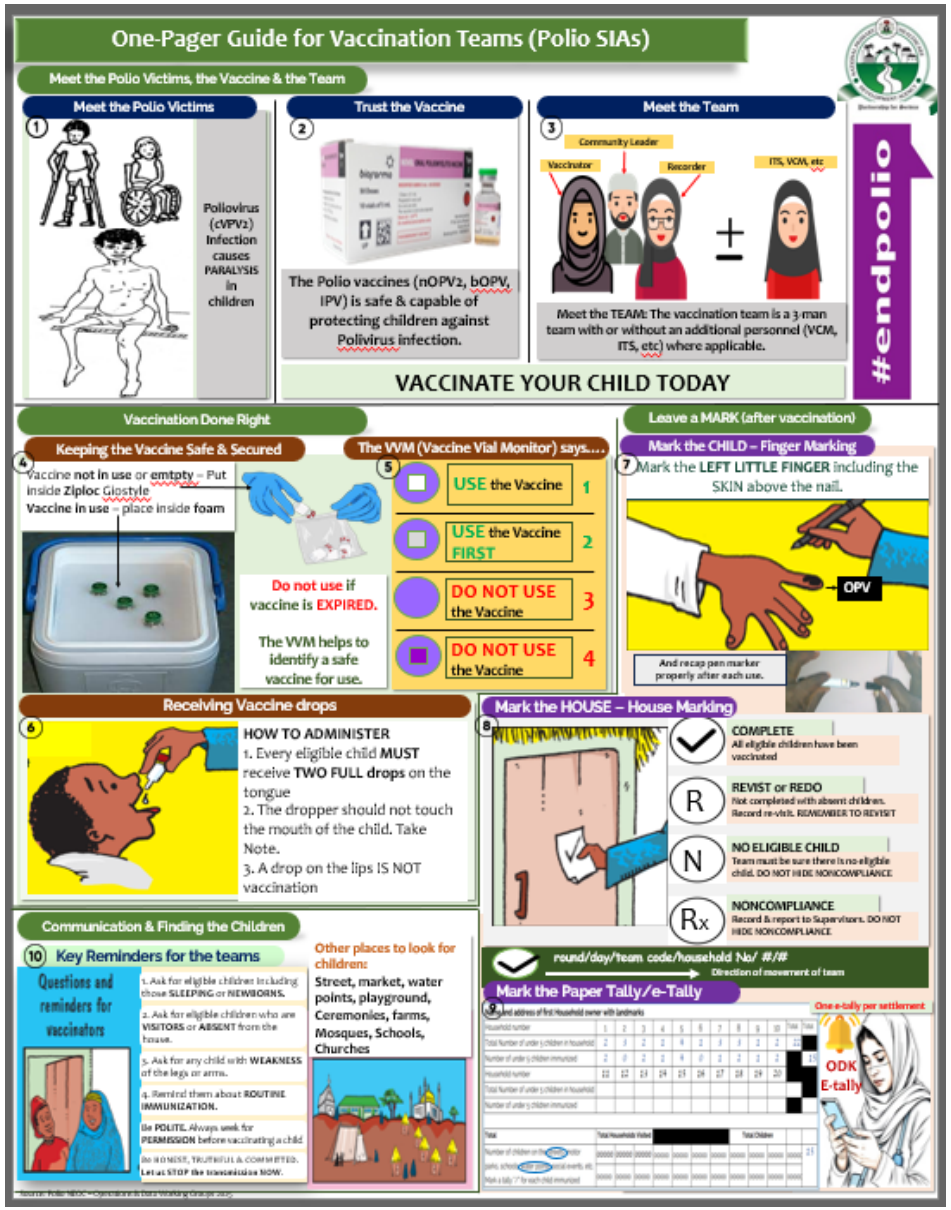
Set ground rules

Validate and verify participants

Apply training checklist

Be familiar with the content

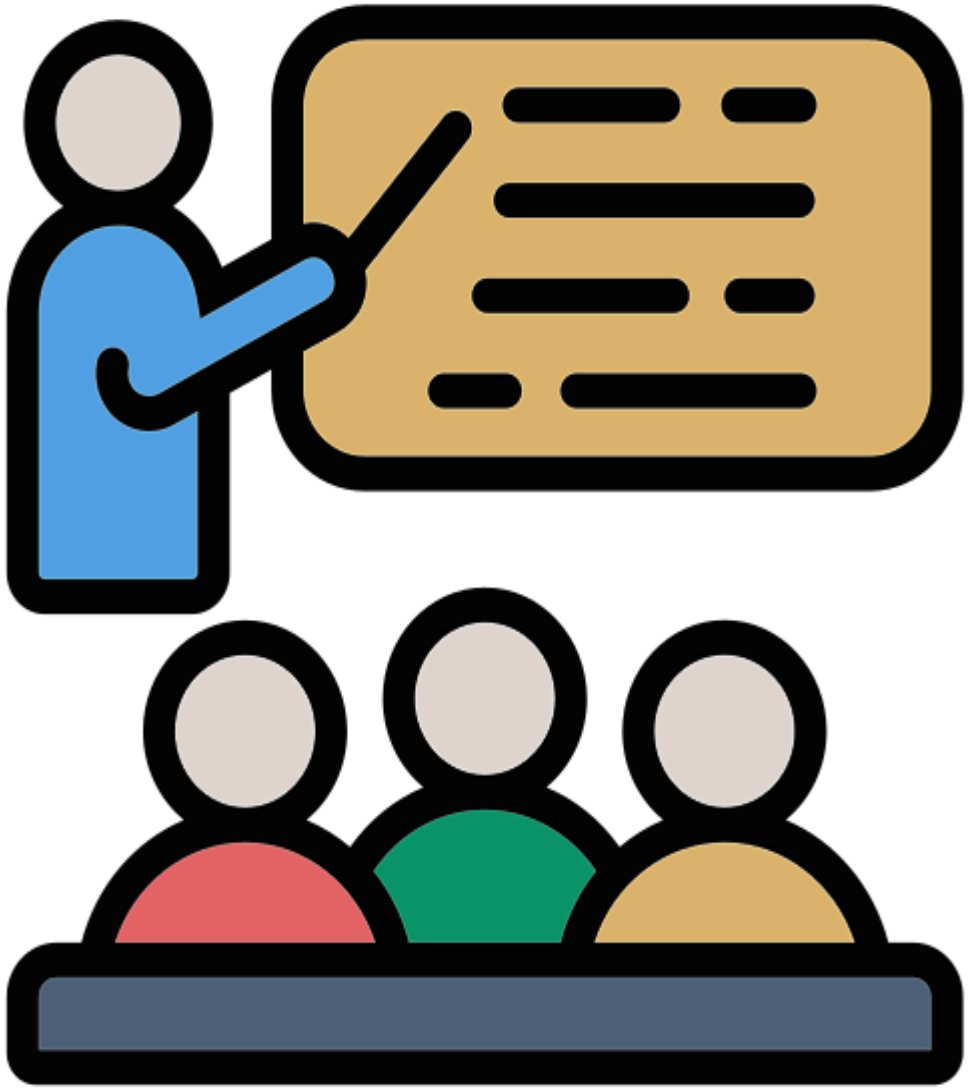
Back-Up



One-Pager Guide for Vaccination Teams

SOPs for Training Vaccination Teams

Focus areas	Key changes to be made going forward
Objectives	▪ To achieve high-quality Polio vaccination campaigns
Key Topics /Content	▪ Topics to be covered – – cVPV2 cases & implications – New vaccination strategy (DOH2H, ITS, ICS, etc) – Conducting quality microplanning – Vaccine handling & management – IPC skills for effective engagement of caregivers – Institutionalization of accountability frame work – Effective supportive supervision
Mode of Training	▪ Printed copies of the PPT training materials ▪ Practical demonstrations ▪ Simulation of the actual activity on the field
Timeline	▪ Training should commence **7 days** before the campaign
Training Outcome	▪ Train more than required & only participants that pass post training tests are engaged for IPDs



Thank you

Team Selection

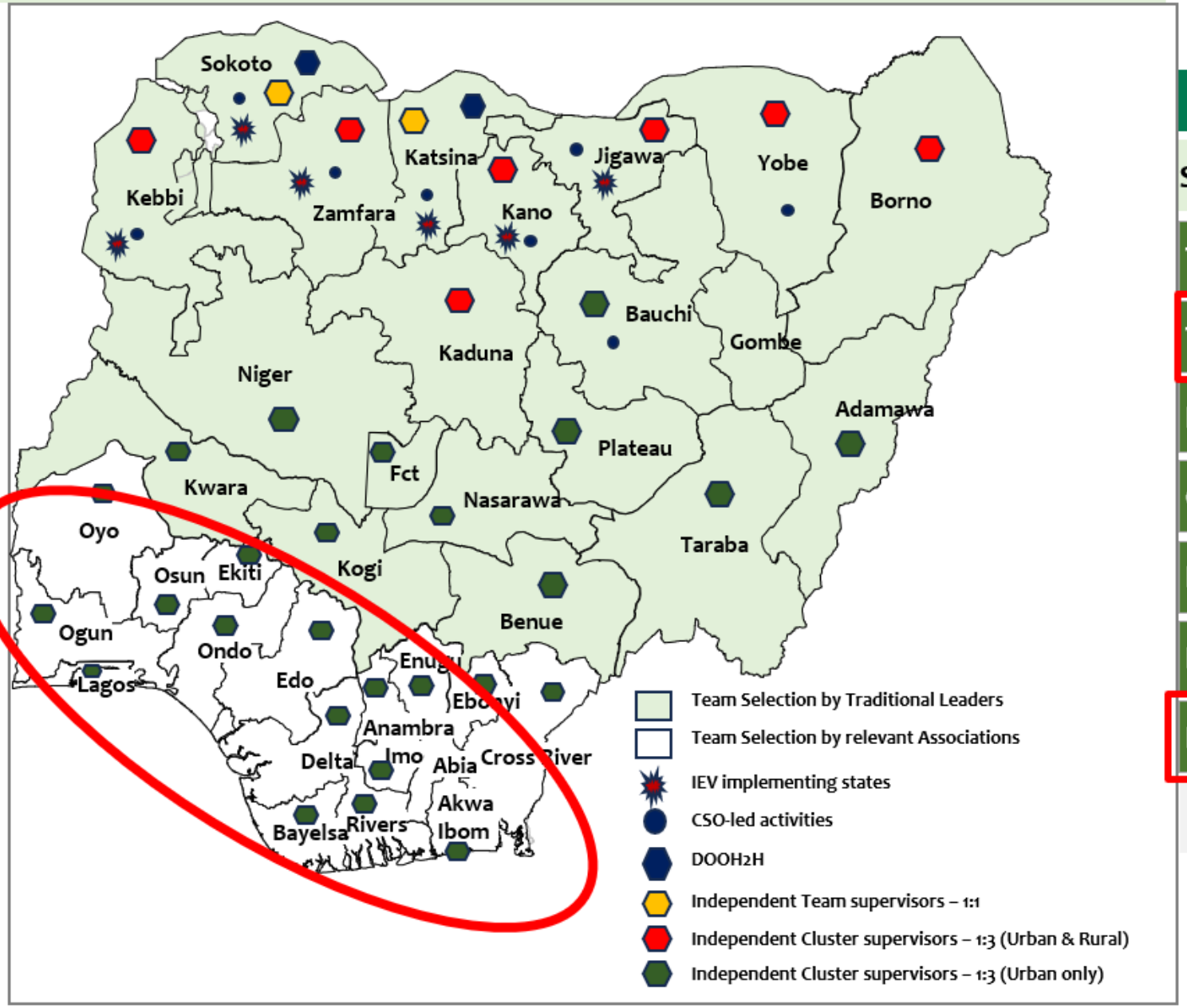
NPHCDA SC/ZTO

Definitions of important players in the revised Team selection process

- **Associations**
  - Southern states will identify, engage & map respected and trusted associations according to context to lead the team selection process eg Church Associations like CAN
  - Good at selecting the right people/proven record.
- **Independent partner-**
  - These are external organizations selected through a competitive process
  - They recruit Independent observers who oversee the Vaccination team selection process
  - The states have no role in the selection of independent partner & independent observer
- **Independent observer**
  - Responsible for the final selection of vaccination teams(recorder,vaccinator & CL)
- **Independent team supervisors(ITS)**
  - These supervisors will be deployed to vaccination teams during the DOOH2H strategy on 1:1 ratio in Katsina & Sokoto during the April campaign but they are independently recruited from the rest of the team
- **Independent Cluster supervisors(ICS)**
  - Recruited from the same source as the ITS but they will be deployed on 1:3 ratio of the traditional vaccination teams in 34 + FCT depending on risk.
- **Traditional Leaders(TLs)**
  - Respected and trusted local leadership structures were they exist should be utilized-mapped & engaged

Map of Nigeria showing the spread of activities across states

Map highlighting plans for the April campaigns across the Federation



Scope of implementation of the 2025 strategic shifts

Strategic shift	# states
Team selection by Traditional Leaders	19 + FCT
Team selection by Associations etc.	17
IEV implementing states	6
CSO-led demand generation states	8
Independent team supervisors 1:1	2
Independent Cluster supervisors 1:3 *(Urban & Rural)*	7
Independent Cluster supervisors 1:3 *(Urban only)*	27+FCT

- The accountability framework is cross-cutting and will be tracked across all states.

Objective of the Revised Team selection Protocol

- **Overall Objective**
  - To ensure right competent personnel are recruited under the direct observation of an independent observer from the associations

- **Specific objectives**
  1) To guarantee all vaccination team personnel are selected under the supervision of an independent observer
  2) To ensure adherence to set team selection guidelines are followed

Scope of implementation of Revised Teams selection for the southern states

Associations/TLs depending on context	**17**

Shift in Team Selection Protocol

Component	Old Protocol	Revised Team Protocol
Nomination & Screening of Vaccination Team members	LIOs with WFP/WSC –no specific structure to hold accountable only individuals	**Associations(CAN)/TLs as per context (Igwe,Oba)**
Training	WHO, State , partners	WHO,partners & state team & provide **provide oversight**
Team selection	WHO,State and partners	• Conducted & Completed after QUALITY TRAINING by Associations/TLs
Verification of Team	Commcare at the ward take off point	• Commcare at Training venue ,with selected candidates providing passport size photos for a photo album • Plan B: Associations & TL verify in the absence of commcare & countersign
Supervision during campaigns	Traditional Team supervisors from H2H Teams	Independent Cluster Supervisors(ICS)

Revised team selection approach using Associations

Overview of revised team selection approach

Associations will support the team selection process from nomination to final selection of qualified candidates

- The Associations ensures only candidates who passed the post test are selected & enrolled by Commcare
- Associations will **be held responsible & accountable for any act of default during Nomination & screening**

Key functions of the Associations

- Assess list of screened candidates at training site to ensure they met the criteria
- Supervise Training for quality
- Collate & share list of finally selected personnel with stakeholders

Sources of Associations

- From :**Education institutions, Respected & trusted local Associations-state specific,churches**

Steps	Nomination & screening of personnel	Training & Selection	Deployment & Verification
Details	❑ Potential team members are nominated by the community leaders(Igwe,Oba) from the team catchment area supported by associations ❑ Nominated team members are screened based on the eligibility criteria by associations	❑ Qualified candidates are trained by WHO, ❑ The best performers (post-test) will be considered for final selection GPEI partners ❑ Biometric verification by commcare team + photos	❑ LIO, WFP, and partners will develop Deployment Implementation Plans (DIPs) , GPEI provides oversight ❑ Independent Cluster Supervisors will verify team members in the field using photo album

Nomination & Screening Criteria for vaccination team members

House - to – House

- **Recorder;** ≥25 years , trusted & respected members of the communities, Women, able to read and write, have & ability to use *an* android phone is-must.

- **Vaccinator:** ≥25 years ,trusted & respected members of the community. Preferably influential women such women group leaders

- **Community leader**; Respected Traditional Leader resident in the area. Should be available to respond to needs of vaccination team and resolve issues

Transit Teams

- **Recorder:** ≥ 25 years , literate, able to read and write; preferable residing within the community (able to use an android phone)
- **Vaccinator;** ≥ 25 years, and respected member of the community, residing in the assigned community
- **Community mobilizer**: Must know the catchment area well and be known and respected, preferably community leaders. Town announcers should have access to a megaphone or other appropriate instrument to attract attention

The independent selection of teams for polio campaigns will follow a clearly defined process

Nomination

Description

Who can nominate candidates?

- Community leaders supported by Associations

What are the criteria for nominees?

- Resident in the catchment Area
- ≥ 25 years and respected member of the community
- Able to read and write
- Vaccinator & recorder must be female(context)
- CL resident of catchment area

Screening

Who be responsible for screening nominees?

- Associations eg CAN etc

What will be done at screening?

- Validation of documents (National ID card, valid bank account in National ID name and/or Degrees or school certificates)
- Confirmation of residency by community Leader
- Oral engagement to gauge comprehension skills

Training and team selection

Who be responsible for training the shortlisted H2H teams?

- **WHO,** state and partners-Train
- **Associations** –Select
- **TLs-** endorses

What are the training specifics?

- LGA level training
- 1-day period (Max of 50 persons per hall)

Activities at training

- Lectures/practical's/role plays
- Post-test
- Team selection (+ 20% buffer)
- Capture bio-data, get photos for verification

Verification & Monitoring

Who is responsible

- Independent Cluster supervisors (ICS)
- Acasus (Accountability partner)
- MSTs

How will participation be monitored?

- **Takeoff (PHCs)**
  - Check photo albums .
  - Attendance ODK
- **In the Field**
  - **ICS Spot Checks) –**using photo albums
  - **MSTs/Acasus**
    - Photo album and biodata
    - ODK feedback

Steps in Nomination & screening of Vaccination Team members

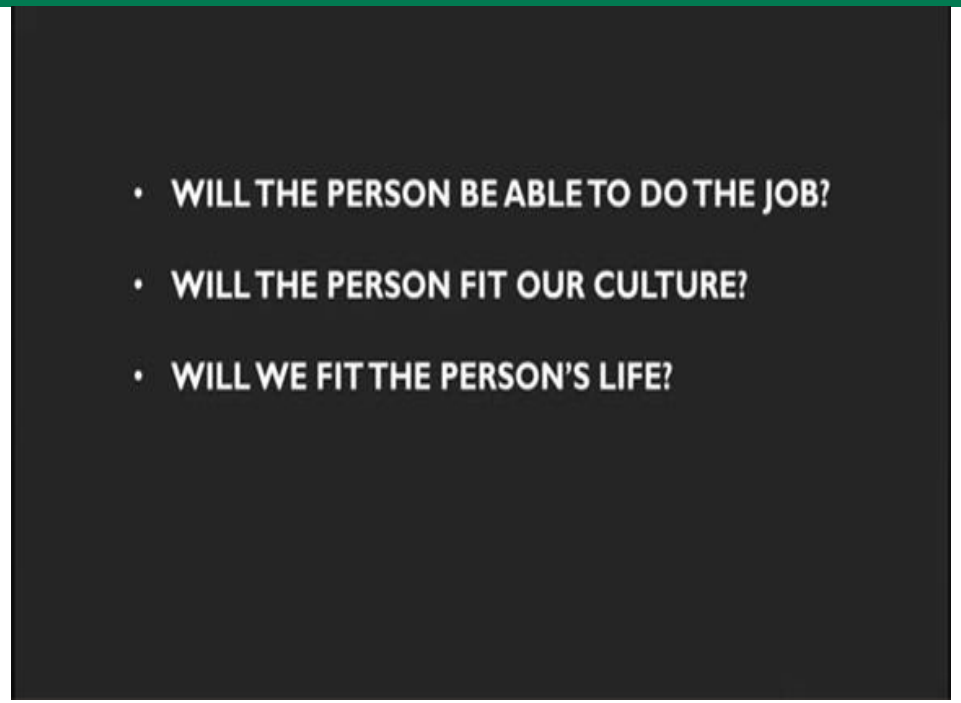
State team & partners identifies and engages associations/TLs about the campaign & their involvement in the team selection process

Associations /State local traditional institutions engage respected health institutions for potential team members

TLs from community / Associations nominate and screen potential team members in line with defined criteria (with a buffer)

Associations collates lists of nominated and screened candidates

Associations sign off on nomination lists and send to WHO for training



Steps inTraining,selection,Deployment & Verification of Vaccination Team members

TRAINING & SELECTION

1WEEK BEFORE CAMPAIGN

WHO, state team & partners trains potential team members and conducts **post test**

Candidates come to training centers with **passport** photos

The Associations makes **final selection decision** from trained team members

Commcare team conducts biometric verification.

If absent **Associations** should be present (PLAN B)

Associations signs off and sends list of **final selection** to State team & LGA teams

3-6th May 2025

DEPLOYMENT & VERIFICATION

LIO and WFP and partners will develop DIPs

Deployment of vaccination teams (and replacement team members) from this trained and selected pool

Participants are verified in the field by independent supervisors using a photo album

Objectives & Responsibilities of Independent team/cluster supervisors (ITS/ICS)

- **Overall Objective**
  - To provide quality supervision and monitoring of the vaccination team activities during campaigns.
- **Specific objectives**

- To guarantee that all eligible under-5 children vaccinated with two drops of nOPV2 and receive their pluses.
- To ascertain accurate reporting of data (Vaccination, Noncompliance, Child absence etc.).

Supervision type	Vaccination teams	Implementing states	Supervisory Tool
ITS	1:1	2-Katsina & Sokoto	ITS Tool
ICS	1:3 rural & rural	7 States Borno, Kebbi, Kano, Jigawa,Yobe,Kaduna & Zamfara	ICS Tool
ICS	**Urban**	**27(includes Southern States + FCT**	**ICS**

- Observe the vaccination activities, offer immediate corrective action and document observations & findings into the Tally sheets
- Ensures that noncompliance and children absent are reported to the Ward Focal Person
- Ensure all team members including self attend daily Ward review meetings.
- Provide a daily report on team activities, including challenges and recommendations
- Report any irregularities or misconduct to the Ward Focal Person and LGA Team

Criteria for the selection of Independent team/Cluster Supervisors

- **Inclusion criteria:**
  - **Individual**
    - Female candidates strictly. Aged 20 years and above and physically fit
    - workers
  - **Possible Sources**
    - NYSC members
    - Students from Universities, health training institutions (nursing), Polytechnics, Colleges of education, etc.
    - Church Associations e.g. CAN etc.
    - Government workers such as teachers (People outside the health sector)
    - Retired health Social workers
    - Literate in English and/or Hausa
    - Has access to and capable of operating Android phone
    - Willing to work wherever they are assigned

- **Exclusion Criteria**
  - Any active Health worker in the LGA
  - Any person has worked with both the Polio and Non-Polio campaigns and has been sanctioned for any campaign malpractice

- **Applicants are screened based on qualifications below:**
  - Educational background (relevant education certificates and diplomas)
  - Experience in immunization campaigns, community engagement, or Polio eradication programs
  - Leadership and communication skills

- **All screened candidates are mandated to participate in training sessions organized by the state and partners:**
  - Campaign Goal, DOH2H & routine IPDs strategies.
  - Activities of vaccination teams including tally sheets, ODK, cold chain and vaccine management
  - ITS/ICS Supervisory checklists for monitoring team performance

Daily Activities of independent Cluster Supervisors

Meet with assigned teams at the take-off point and attend early morning refresher training

Crosscheck on the DIP & Community Leader if they are in the right settlement

Observe the administration of two OPV drops every child.

Ensure the vaccinator marks the child's finger after vaccination.

Identify & immediately offer corrective actions for fake finger marking, data falsification, concealment of no compliance

Confirm with Community Leader if all households have been visited before moving to the next settlement

Counter sign on the tally sheet as confirmation of completion before moving to the next settlement.

Attend ward level ERM

Process flow of the selection of Independe Cluster Supervisors (ICS)

State team communicates and engages institutions for required personnel

- NYSC
- Universities,
- health training institutions (nursing), Polytechnics,
- Colleges of education

Institutions create a shortlist of candidates

State team & partners works with institutions to screen candidates against defined criteria

WHO, State & partner trains screened candidates at the LGA level

GPEI partners selects the independent supervisor(ICS) based on post-training performance

Partners submits the final list of ICS selected to State team and NEOC

Process flow of the Deployment & Monitoring of ITS/ICS

Deployment -25-26th April

State team, partners, LIO & WFP develops deployment plan of ICS and then submits to the

GPEI partners shares deployment plans with IS and mobilizes them to LGAs/wards

ITS & ICS are deployed in different ways during campaign

ITS
1:1 in Sokoto and Katsina

ICS
1:3 in 34 states + FCT

GPEI partner shares deployment plans with IS and mobilizes them to LGAs/wards

Monitoring (26-29th April)

ICS collect data on team performance through ODK checklists

Data on team performance is fed real time into dashboard

Performance issues identified from the real-time dashboard are reviewed during evening review meetings and used to take corrective action

Thank you

Discussions

ALL

Development of Microplan & DIPs

WHO VPDs TA

Presentation outline

1. Background
2. Strategic shifts – Traditional Micro-plan for Polio SIAs
3. April 2025 NIDS micro planning exercise
4. Verification and validation of micro plans

Source: Team analysis

Background

What is micro planning?

A detailed bottom-up planning process for optimizing immunization and other PHC services, conducted at lower levels and aggregated at higher levels

Details of human, material, and financial resources required to reach the target population for routine immunization, SIA, and other primary health care services

Goal of Microplanning:

To reach all settlements with scheduled PHC services to leave ***no one behind***

Specific Objective

- To develop ward plans that capture all settlements/ hamlets, security-compromised compromised, new settlements, and hard-to-reach areas
- To ensure that previously missed populations are included in immunization plans and are reached with potent vaccines and other PHC services
- To ensure that all resources (personnel, material & financial requirements) are properly ***and adequately mapped out***

Scope of the Microplanning Process

A. Workload Rationalization

(Identify and Enumerate States)

1. The affected states are: Kebbi, Sokoto, Zamfara, Katsina, Jigawa, and Kano
2. Workload rationalization (Commences immediately after the IE)

B. Mini Walkthrough Micro plan

(Non-IE States)

1. Mini-walkthrough (April 16th – 23rd); the affected states are: Adamawa, Borno, Gombe, Yobe, Taraba, Benue, Plateau, Bauchi, Nasarawa, Kaduna, FCT, Kogi, Kwara, Niger, Kwara, Oyo, Osun, Ekiti, and Ondo etc,.
2. Their focus will be:
   - Expanding or emerging settlements(especially metropolitan areas such as outskirts of states and LGA headquarters)
   - Missed settlements from previous campaigns
   - Areas with temporary settlements such as IDP & refugee camps
   - Areas with consistently poor performance during campaigns, e.g., high missed children
   - Areas with irrationally high or low team workload
   - Underserved and border settlements
   - Security-compromised areas

Source: Team analysis

Reasons for strategic shift from traditional microplanning for Polio SIA's

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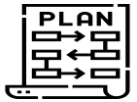
				
	Persistently missed population during polio campaigns	**Irrational workload**	**Migrant populations**	**Problems of in-proper microplanning**
Challenges	▪ Missed household and household not in microplan ▪ Missed/ new settlements ▪ Lack of visit by vaccination teams ▪ Households not visited have been the major cause of LQA's failure	▪ Team's inability to cover catchment areas due to inadequate teams' allocation ▪ Teams closing early due to few settlements allocated	▪ Nomads ▪ Economic migrants ▪ Fishermen ▪ Seasonal/irrigation farmers	▪ Funds are released for MP updates with no clear impact, and desktop-based development is common. ▪ Poor planning, logistics issues, and stockouts disrupt campaign execution. ▪ Supervision is inadequate, urban-focused, and ACSM activities miss key populations
Plan	▪ Identify and plan for the persistently missed populations/ emerging settlements	▪ Ensure equitable distribution among teams and in all the days of the campaign	▪ Map out formal and informal borders and station teams to ensure vaccination of migrant populations	▪ Ensure adequate resources are deployed based on MP ▪ Deploy supervisors across LGAs and wards

Source: Team analysis

Summary of The Mini-Micro Planning Process, April 2025

State Level Training

LGA Level training on MP

Desk Review of previous MP

WFP returns to the ward for planning meeting with stakeholders.

TS with TL ,Youth Leader conduct walkthrough

-Looking for boundary, new structures etc

TS with his colleagues shares findings with all stakeholders in the catchment area for validation

TS submits validated MP to WFP for compilation

WFP with support from TS prepare Ward MP

Each WFP submits to LGA team for validation

Advocacies and planning meetings at the LGA level

Advocacy to LGA Chairman

- LGA team with partners to conduct an advocacy visit to the LGA chairman & his council members, key traditional and community leaders
- Advocacy briefs to cover purpose, importance, period, expected outcome and role of all stakeholders

LGA Planning Meeting

- Participants for this meeting are: LGA Team, Ward focal person, Heads of Health facilities, Partners, NGOs, Community leaders, Councilors.
- The meeting should
  - Update the LGA Master list of Settlement
  - Review previous LGA micro-plan
  - Define/redefine wards' Boundaries
  - Develop an LGA map (Preferably GIS Map)
  - Indicate key structures in the LGA (LGA secretariat, PHC dept, major roads etc).
  - Allocate LGA team member that would supervise a cluster wards for the MP development
- After the planning meeting at LGA level, the Ward focal persons move to the ward to conduct ward planning

Steps for The Mini-Micro Planning Process, April, 2025

Activity	Expected Output
Step 1- Updating the Master list of Settlement • The WFPs should convene a meeting of all community leaders in the Ward and Team Supervisors. To update the list of special places	• Updated list of settlements developed • The list of all the special places developed • Map of the updated list of settlements and special places developed
Step 2- Allocation of catchment area to house-to-house vaccination teams • WFP should ensure all the settlements are allocated to H2H teams	• House-to-house team catchment area defined – ensuring no conflict of areas between teams
Step 3 - Each TS and CL will conduct a walkthrough of the catchment area to • Count all the households in a settlement/street – A Simple inquiry of the number of households in a house should be made and tallied in form 1a.(1/settlement)	• Completed form 1a for all the settlements • Sketch a map of the settlement • Completion of the summary form (form 1b) by WFP

Source: Team analysis

HH & No of children enumeration Tally sheet & Listing of special places

HH & No of < 5yrs enumeration Tally sheet & Listing of special places- Nigeria

State_____ LGA_____ Ward_____ Team Code_____

Date_____

Name of Team supervisor_____ Phone Number_____ Name of Comm. Leader:_____

Settlement Name:	Number of households & Children per HH Counted (Mark a Tally "I" for each household & No. of children per HH)																		Total No. HHs	Total No of < 5yrs
	HH No.	No. of <5 yrs.	HH No.	No. of < 5yrs.	HH No.	No of < 5yrs.	HH No.	No. of <5 yrs.	HH No.	No.of. < 5yrs	HH No.	No. of < 5yrs	HH No.	No. of < 5yrs	HH No.	No. of <5 yrs	HH No.	No < 5yrs	HH No.	No. of < 5yrs		
Name of Ist HH:	1		6		11		16		21		26		31		36		41		46			
Mid point landmark:	2		7		12		17		22		27		32		37		42		47			
Name of last HH:	3		8		13		18		23		28		33		38		43		48			
Settlement Profile =Tick = Urban slum /Urban /Rural /Scaterred	4		9		14		19		24		29		34		39		44		49			
	5		10		15		20		25		30		35		40		45		50			

List of special Places

Name of Special Place	Estimated <5 TP	Name of Special Place	Estimated <5 TP

Signature of TS Supervisor::_____

_____

_____Signature of the Settlement Head_____

List of special places

Map of the Vaccination Team Catchment area showing day by day activity

Listing of Important Places to be covered													
Day of activity	Name of settlement	Exact Location and Name of the Important Places (Eg: School* / Market* / Mosque / Church / Motor Park/ Playground / Water Point / Clinic - Government & Private / Farms)	Church		Schools				Market		Planned timings for Visit / Visits	Number of Target Children
			Weekly	Daily	NASFAT	Islamic	Nursery	Primary	Weekly	Daily		

Steps for The Mini-Micro Planning Process, April, 2025

Activity	Expected Output

Step 4 – Workload rationalization
• The Team supervisors and the WFP will further rationalize the workload to ensure equitable distribution among teams and in all the days of the campaign.
• As a guide, a team is expected to cover these number of HHs:
  • Urban slum – 150-200 HHs
  • Urban – 100-150HHs
  • Rural – 80-120 HHs
  • Scattered area – 60 – 80 HHs.
  • The TS under the supervision of WFP will divide the catchment area into 4 workdays
	• Rationalization of Workload among the teams by the WFP
	• Daily workload rationalization by each team

Step 5 – Development of Daily implementation plan (DIP) • The rationalized workload is transcribed into the DIP.	• DIP is developed & Daily route map developed • Tentative transport logistics plan developed
Step 6 – Development of DIP of transit teams • All the big special places (places with =>50 under 5yrs children) in the ward are pulled out and placed in transit team's DIP - STMT1; while the remaining special places (<50 children) are included in the DIP of H2H teams- H2HMT1a	• Transit team DIP developed • Tentative Transport logistic plan for TT determined per TT/day

Source: Team analysis

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
FEDERAL MINISTRY OF HEALTH - NIGERIA
Daily Implementation Work plan - House to House Vaccination team

IPD / SIPD / Mop up_____20__ Team Code_____

State_____ LGA: _____ Ward:_____ Name of the WFP_____ Gender : Male / Female; Residence_____ GSM Number_____

Name of the Team Supervisor:_____ Gender : Male / Female Address_____ GSM Number_____

Name of the Vaccinator_____ Gender : Male / Female Residence of the Vaccinator_____ Name of the Village Head_____ GSM Number:_____

Name of the Recorder_____ Gender : Male / Female Residence of the Recorder_____ Name of the ARDOS (If Present):_____ GSM Number:_____

Name of the Community Leader_____ Residence of the Community Leader_____ GSM Number:_____

	Day 1		Day 2		Day 3		Day 4	
Name of the Settlement / Ruga / Urban Area - Street								
Distance from the Take off Point and time required to reach the settlement								
Type of Transport Required (encircle)	Walk / Motor cycle / Car / Keke NAPEP / Jeep / Boat		Walk / Motor cycle / Car / Keke NAPEP / Jeep / Boat		Walk / Motor cycle / Car / Keke NAPEP / Jeep / Boat		Walk / Motor cycle / Car / Keke NAPEP / Jeep / Boat	
Settlement Profile - Indicate profile of the settlement from the type suggested below								
Does this Settlement have scattered households associated with it? If yes, list head of the households on the scattered area template	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Is the Settlement / Urban area High Risk?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Name of the First Household Owner with landmarks (Start Point)								
Via / Midpoint / Landmark								
Name of the Last Household Owner with landmarks (End Point)								
Important Places to be covered by H to H team (Encircle appropriately & write down the details of site to be covered) . Also list detailed address of each site in detail on the back of the template	School - Quranic, Islamic, Nursery, Primary / Market / Mosque / Church / Motor Park / Playground / Water Point / Private & Government Clinic / Farms		School - Quranic, Islamic, Nursery, Primary / Market / Mosque / Church / Motor Park / Playground / Water Point / Private & Government Clinic / Farms		School - Quranic, Islamic, Nursery, Primary / Market / Mosque / Church / Motor Park / Playground / Water Point / Private & Government Clinic / Farms		School - Quranic, Islamic, Nursery, Primary / Market / Mosque / Church / Motor Park / Playground / Water Point / Private & Government Clinic / Farms	
Team Meeting Point								
Social Event								
Name of Ward / Settlement Head								
Number of Households Planned to be visited								
Vaccine Doses Required								

Signature of the Team Supervisor_____ Signature of the Group Supervisor_____ Signature of the WFP_____ Signature of the STF_____ Signature of the Village Head_____ Signature of the Ward Head_____

(1) Prepare on the reverse of this sheet a detailed map of the team catchment area with clear boundaries showing each day of work area, important Landmarks, Start & End Points & Meeting Points (2) List in detail other important places on the back of the template and indicate day and time of coverage (3) If more than 1 settlement per day, use the dotted line to record each settlement separately, if more than 2 settlements per day, use another template for the additional settlements; (4)Profile of the settlements : Urban / Rural ; Densely Populated, Slums, Scattered, Border Settlement, Nomadic, Fulani, Riverine

Transit Team DIP

IPD / SIPD/ Mop up_____20_____ Team Code_____

State_____ LGA: _____ Ward:_____

Name of Ward Focal person_____ Address:_____ GSM Number_____

Name of the Vaccinator_____ Name of the Recorder_____ Town Announcer_____

Day of Work		Site 1	Site 2	Site 3
Day 1	Site			
	Location of the Site			
	Timing of Visit (Start to End)			
Day 2	Site			
	Location of the Site			
	Timing of Visit (Start to End)			
Day 3	Site			
	Location of the Site			
	Timing of Visit (Start to End)			
Day 4	Site			
	Location of the Site			
	Timing of Visit (Start to End)			

Signature of the Senior Supervisor_____ Signature of the WFP_____ Signature of Village Head_____

Planning for inaccessible settlements

- Please note that all settlements that could be accessed by indigenes/Residents of the settlements should follow the presentation above in the development of their MP :
- While insecure settlements that will require the presence of security personnel (hunters, vigilante, Police and Army) should use the guide below:

  - *List all the settlements that require security personnel to access*
  - *Cluster the settlements and develop DIP*
  - *Identify the type of security personnel required*
  - *Determine the number of security personnel required*
  - *Determine the mode and cost of transportation*
  - *Payment of security personnel*

Planning for inaccessible settlements

Planning for inaccessible settlements														
Date =		Name of LGA =				Name of Ward =								
S/N	Name of settlement	Date	Type and number of security personnel required				Type of transportation	Cost of transportation	Payment of security personnel				Payment of personnel	
			Hunters	Vigilante	Police	Army			Hunters	Vigilante	Police	Army	Supervisor	Community leaders
1	1 2 3 4													
1	1 2 3 4													
1	1 2 3 4													

Steps for Micro plan verification and evaluating the MP development processes

1. Select wards for verification, prioritizing high-risk areas, and randomly choose one team per ward, including teams with known data quality concerns
2. Identify a specific day's workload for assessment and conduct a walkthrough of the selected team's assigned area
3. Work with Ward Focal Persons (WFP), Team Supervisors (TS), and Village or Settlement Heads to enumerate all households and record the number of eligible children
4. Compare the team's reported data in the Daily Implementation Plan (DIP) with the actual findings from the validation exercise
5. Discuss discrepancies with the teams and provide feedback to ensure corrective actions are taken to improve data accuracy

Source: Team Analysis

Example of validation of MP at Ward level

LGA	Ward	Settlement	Tm Code	HH	
				DIP data	Val data
D/Kudu	Gurjiya	Danmaji Riga	81	63	53
D/Kudu	Ungwar Duniya	Gidan Fulani	125	63	22
D/Kudu	Jido	Jido Akjiri	84	73	73
D/Kudu	Yankatsari	Yankatsari	142	62	82
D/Kudu	Tsakuwa	Bahbadawo	122	69	69
D/Kudu	Dawakoji	Koda Ungwa Jamaa	43	86	85
D/Kudu	Yambarau	Riga Dindiya	137	52	52
D/Kudu	Kore	Shamakawa	23	50	49
D/Kudu	Gano	Tashila	176	35	40
Rano	Dawaki	Ungwar Ada'u/Alkalawa	29	80	78
Kiru	Bargom	Gidan Kwajare	34	53	55
Gaya	Kazurawa	Yola Yamma	83	81	64
Dawakin K	Tamburawa	Magami	101	67	58
Bebeji	Gwarmai	Gidan Baure	76	47	65
Albasu	Batayya	Kwangarmi	26	48	79
Garko	Zakarawa	Kafi	122	31	37
Rogo	Falgore	Masalacci	20	80	85
Warawa	Jemagu	Makere Yanma/Lisu Alha Ub	52	79	78
Warawa	Gogel	Kofar Kudu Gidansarki/Kofa	24	83	86
Takai	Kachako	Makara Huta/Arewa	85	95	80
		Total	1585	1297	1290
			% Discrepancy		0.5

April NIPDs 2025 Campaign

Microplan Validation Form

To be used by all supervisors after the Mini microplanning process

Name of State:_____Name of the LGA_____ Name of the Ward_____ Date _____

Name of Validator:_____ Designation: LGAF / LIO / STF / HE / CCO / CC / DPHC / ZTO / SC / ZC / STOP / N-STOP / STC / Partners

Sr No	Questions	Response	Comments
1	Time of visit by of Validator		
2	Name of Ward Focal person		
3	Does the WFP have the developed activity plan for the microplanning proces (Sight and verify)	YES / NO	
4	Was fund(s) provided to the WFP for the microplanning process?	YES / NO	
5	Is there an updated master list of settlements for the ward from GIS? (Sight and verify)	YES / NO	
6	Is there a ward map showing distribution of health facilities, schools, churces/mosques, posts,HTR, etc?. (Sight and verify)	YES / NO	
7	Have the Ward focal person worked with team supervisor(s) conducted the microplanning? (WFP, other Health facility incharges and Traditional leader)	YES / NO	
8	Have the number of vaccination teams determined for the ward?	YES / NO	
9	Did the Team Supervisor complete All the household enumeration template and DIP correctly? (sight and verify)	YES / NO	
11	Have all the Catchment areas been rationalised in terms of workload? Sight please	YES / NO	
12	Were community leaders physically involved in the microplanning process? (Community leader or member of WDC present). Verify by Physically seen, attendance list/minutes of meeting	YES / NO	
13	Is the Daily implementation plan developed (sight and verify)	YES / NO	
14	Does the DIP contain information on (Vaccination post/Site, personel, Vaccine and transport requirement, Map, schools, Mosques, Churches, Markets transit point and important places etc? (Sight and verify)	YES / NO	
15	Has the ward identified personnel for the proposed Campaign? Cross check verify and call some of them GSM	YES / NO	
16	Are there adequate personnel for the proposed Campaign?	YES / NO	
17	Has the Ward Focal person identified the Take-off /meeting point correctly sight on the map	YES / NO	
18	Were any new settlements identified in the ward? (Evidence from the map)	YES / NO	
19	Any Other Issue? e.g. 1. Un-acceptable microplans 2. Ward focal person not found in the field / did not go to the field 3. Others , specify_____		
20	<u>Comments / corrective measures / recommendations</u>		
21	Instructions - Fill the check list during Validation of microplan at Ward level) NB: At least 30% of the wards in an LGA should be verified and information submitted through ODK and also shared with Director PHC/LGA		

Thank you

Advocacy Communication & Social Mobilization

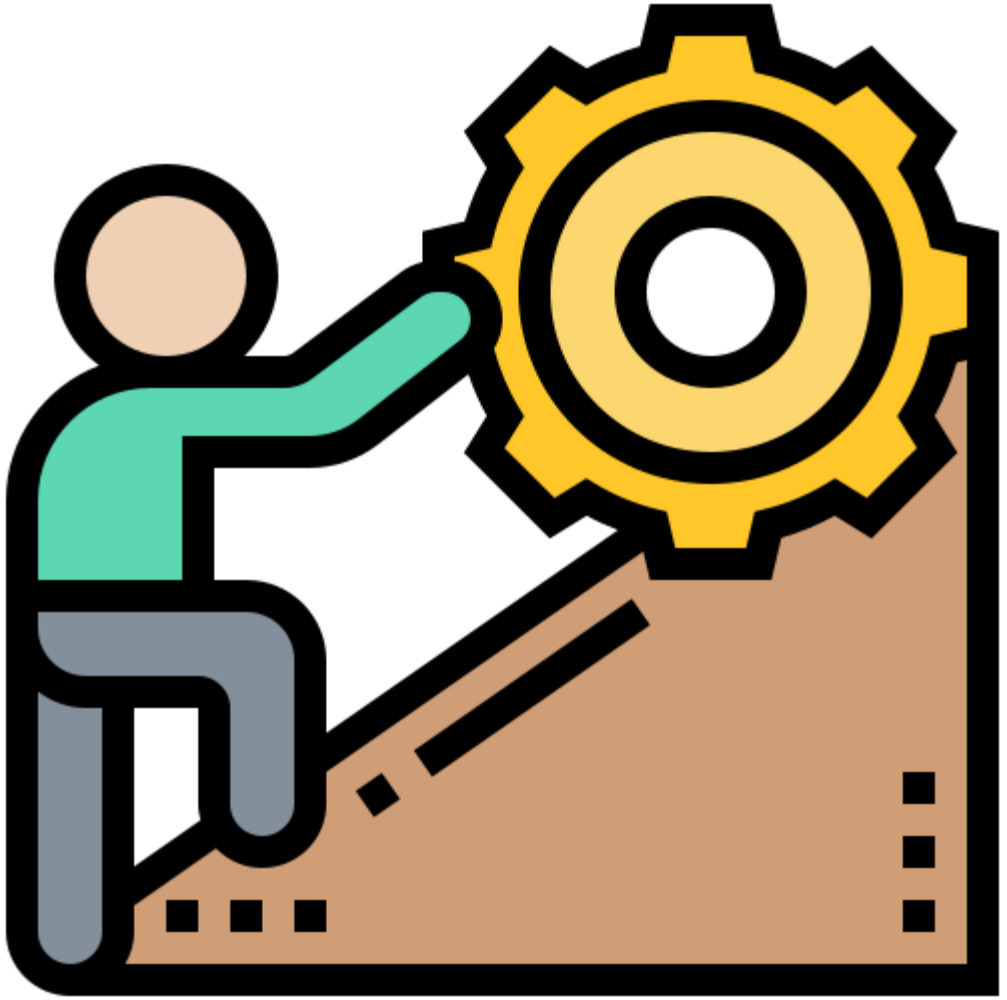
STATE MOBILIZATION OFFICER

Overview

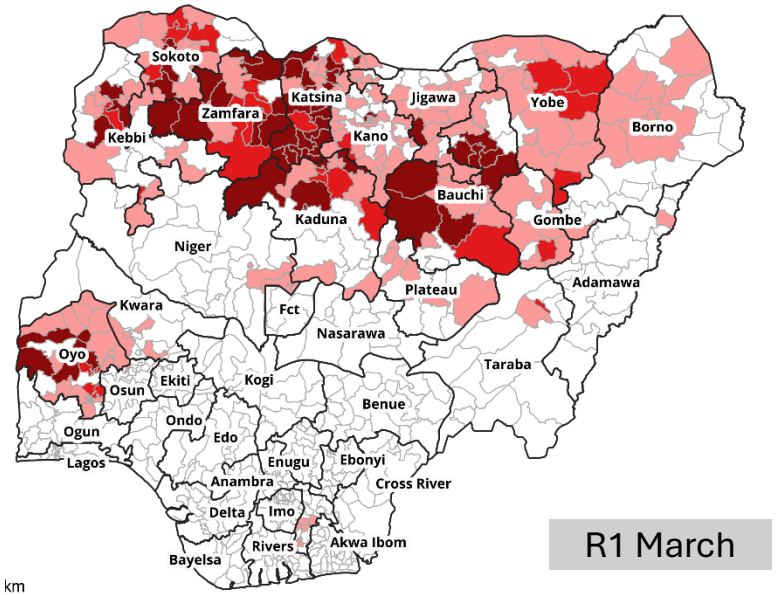
- ❑ Key ACSM Challenges
- ❑ What is Communication
- ❑ Interpersonal Communication
- ❑ Importance of IPC
- ❑ Components of Interpersonal Communication
- ❑ Key Messages

Key ACSM Challenges in Polio Campaigns

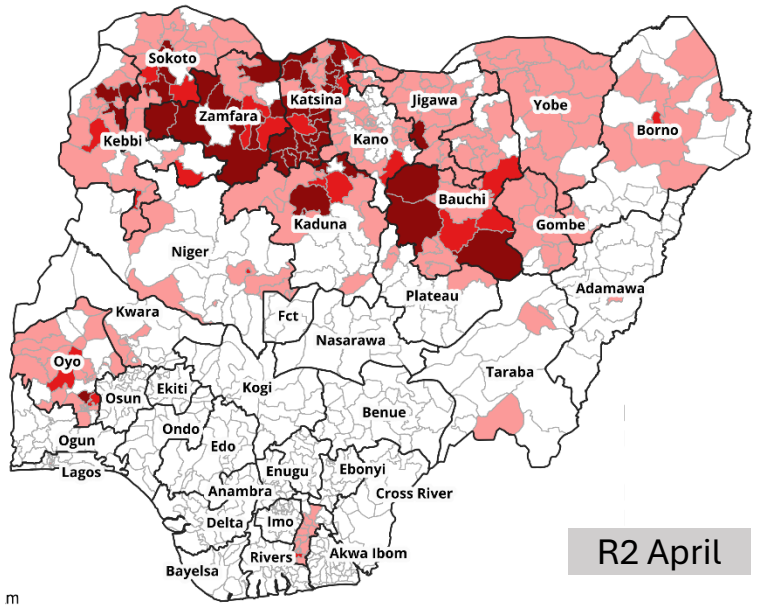
- Non-compliance
- Fake finger marking
- Data falsification
- Poor quality ACSM plans & not targeted
- Suboptimal community mobilization
- Weak engagement of community stakeholders
- Poor documentation & resolution of noncompliance and child absent



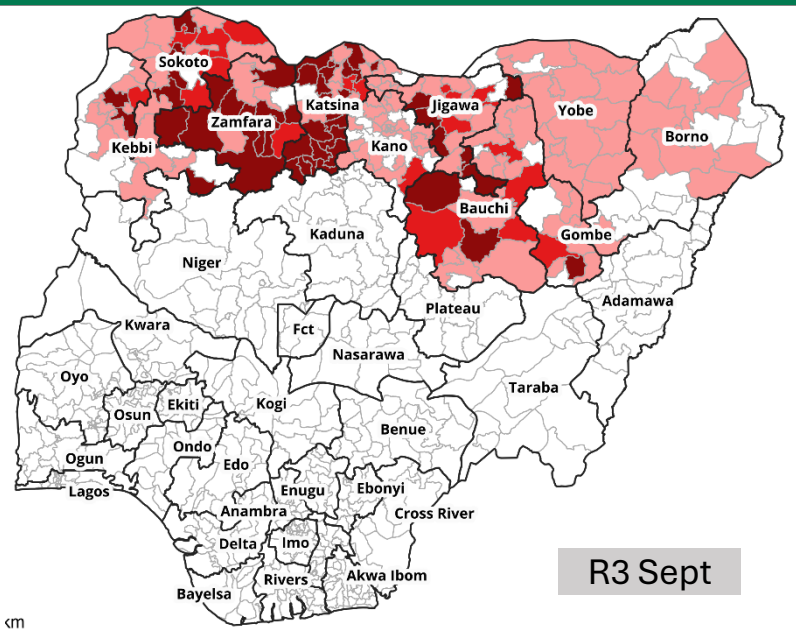
LGAs with pending/unresolved non-compliance cases (NC) 2024 SIAS



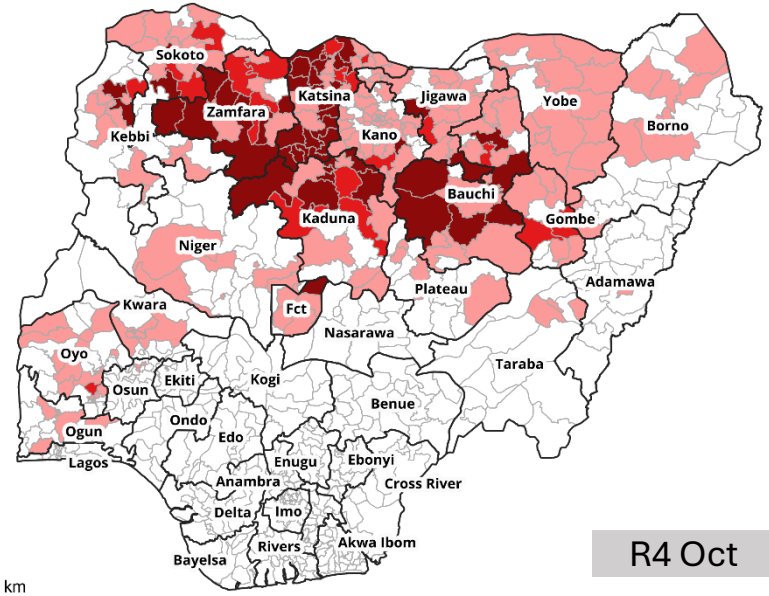
R1 March



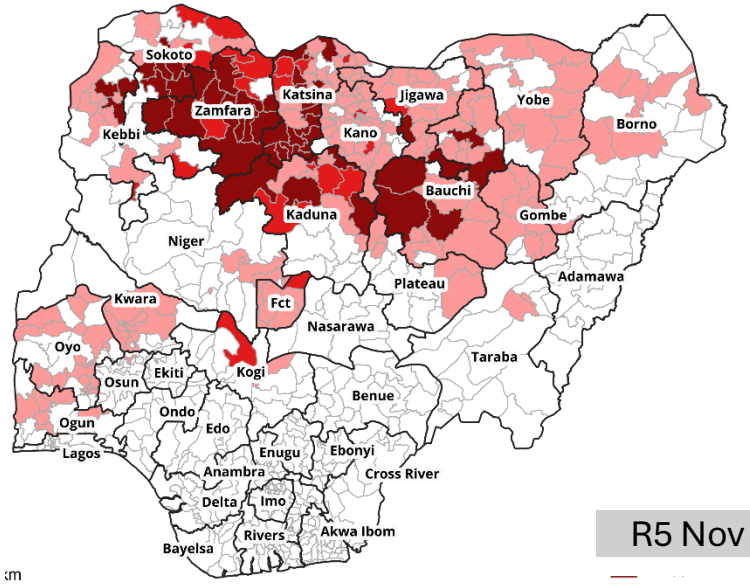
R2 April



R3 Sept



R4 Oct

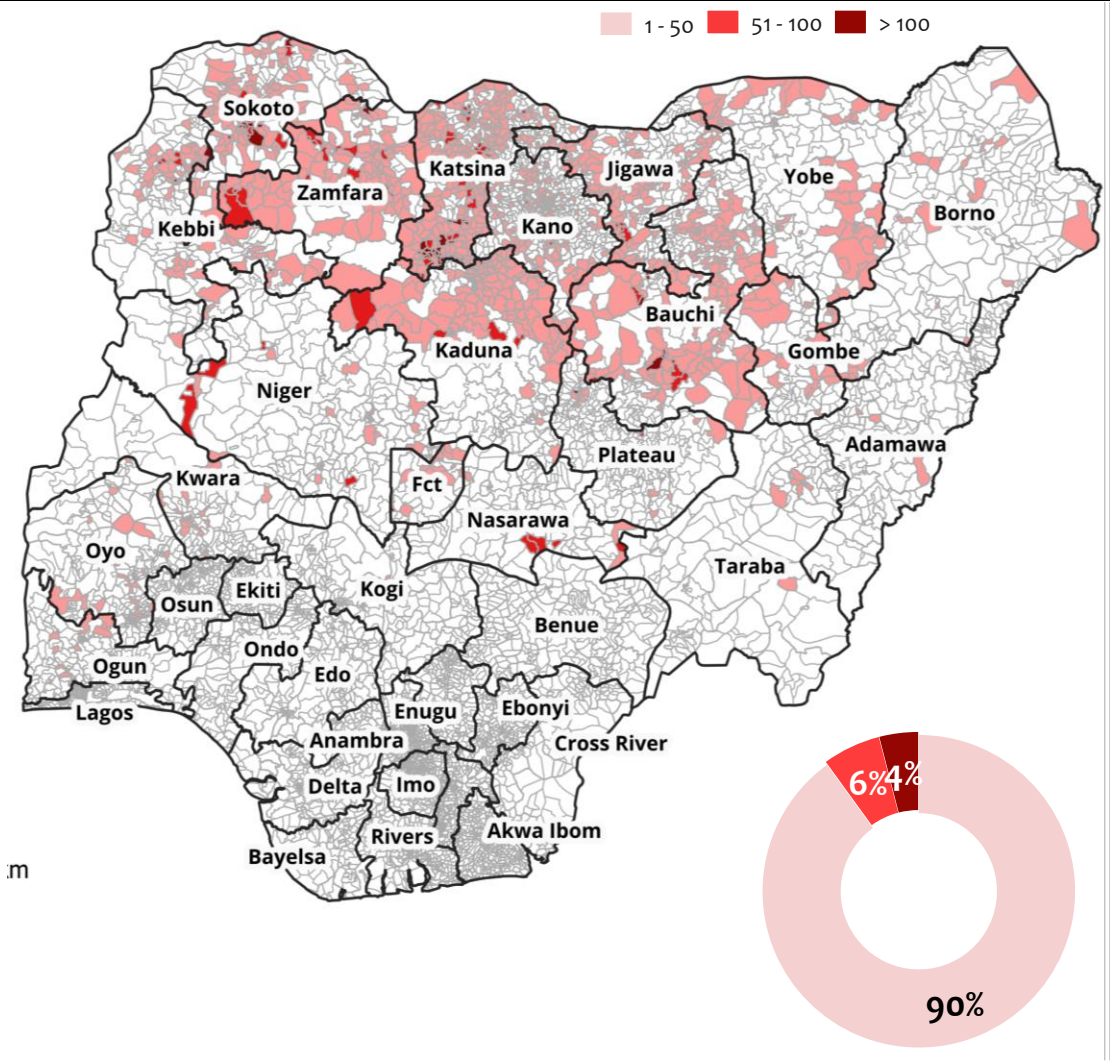


R5 Nov

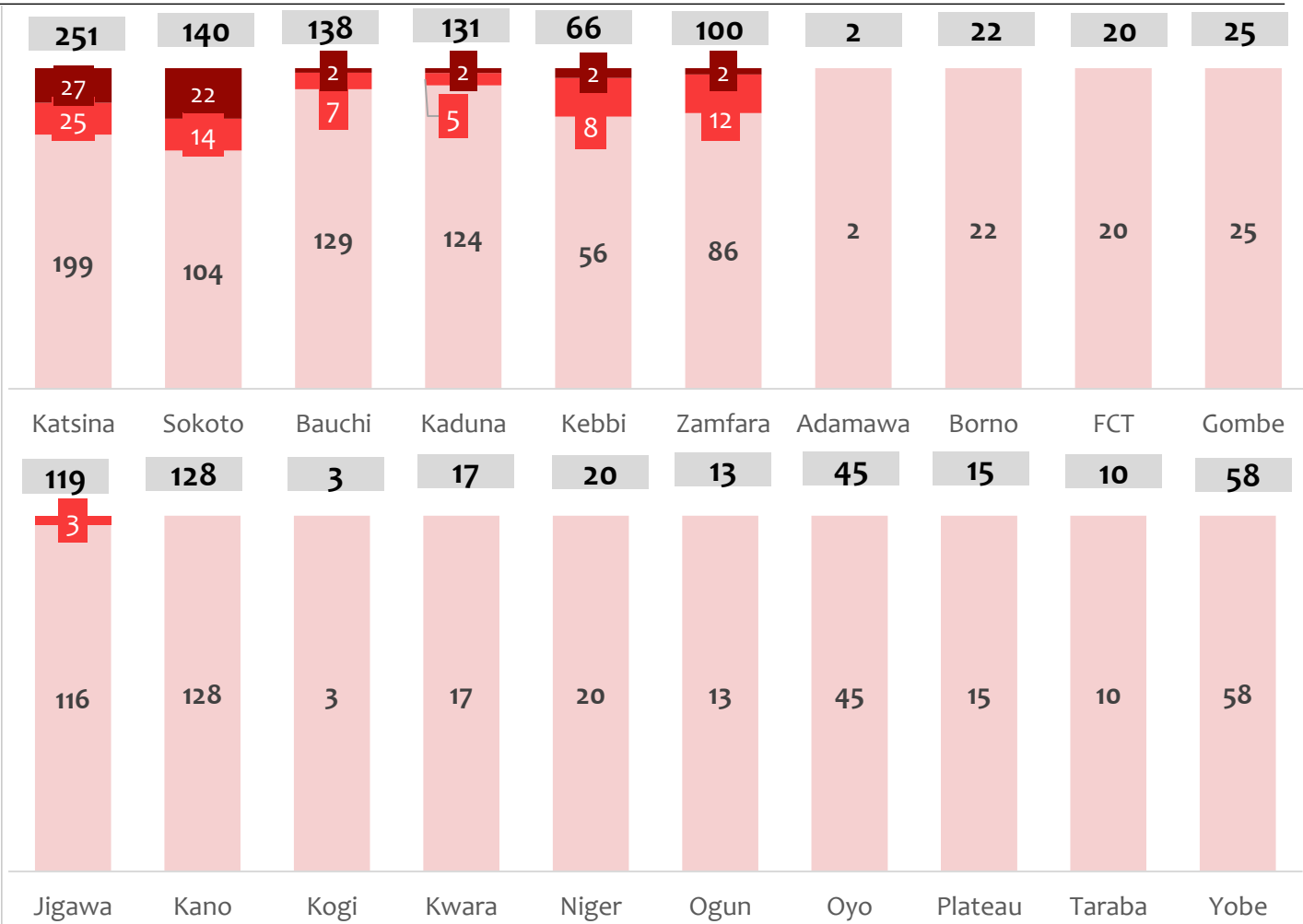
No NC Reported
1 -50 reported NC
51 – 100 reported NC
> 100 reported NC

4% (57) of Wards Still Have Over 100 Pending Non-Compliance Cases After November 2024 OBR5

Map showing the distribution of pending NC by ward after the November OBR campaign



Breakdown of the Number of wards with pending NC cases after the November OBR campaign



SOURCE: November independent monitoring Inside Household

Communication

Communication is the sending and receiving of a message. Communication can occur between one or many different people.

- **Communication** is the sending and receiving of a message. Communication can occur between one or many different people.

Type of communication:

Intrapersonal communication

- ❖ *refers to the conversation that is continually going on in your own mind*

Interpersonal communication

- ❖ *refers to the different types of verbal, non-verbal and physical actions or expressions that people use when they communicate with each other.*
- ❖ involves two or more people

Nonverbal Communication

- ❖ The transmission of information through gestures, images, graphs, and other visual aids.
- ❖ *Strong and effective means to communicate ideas, thoughts and feelings.*
- ❖ *Can simplify complex issues*
- • ***The Quality Of Our Interpersonal Communication*** *Will Determine The Quality Of Our Work And Quality Of Our Life*
- • ***Interpersonal Communication Skills Can Be Learned***

Importance of IPC

- ❑ Provide supportive supervision to health workers and help them convince caregivers to vaccinate their children
- ❑ Communicate with caregivers.
- ❑ Convince non compliant caregivers to accept vaccination.
- ❑ Assure hesitant caregivers about the efficacy of polio vaccine

- ***For community leaders***

- ❑ **Conduct advocacy to relevant influential persons in the communities to support the campaign and resolve non compliance.**

Components of Interpersonal Communication

1. *Conversation*
2. *Listening*
3. *Body language*
4. *Environment*
5. *Self-appearance*

Conversation

Essentials of a good conversation:

1. Greet with a smile
2. Make visual eye contact
3. Talk in a friendly manner - tone Of Voice
4. Be patient if there are questions
5. Ask and Mention Names
6. Use Suitable Language
7. Simplify Your Message
8. Give Other People The Chance To Talk
9. Winning People's Heart - Be Interesting Vs. Be Interested

Active Listening

- Allow people to express their concerns
- Be receptive, not judgemental
- Do not be too fast to conclude
- Take all required time to listen to their concerns and questions
- Do not focus on what you are going to say
- Answer in a convincing manner
- If you don´t know the answer, say you will search for information and give them information when you get it

Body Language

PROPER BODY LANGUAGE

Smile or show happy face

Nod your head - show you are following the conversation attentively.

Give space so that everyone can see each other's face if you are talking in a group.

GOOD BODY LANGUAGE

"Mirroring" is you create the same body posture with those you are talking to – if they are standing with one leg up, you do the same, if they are holding cup, you do the same. - creates friendly and relaxed atmosphere between you and the other person.

Avoid :

- ***Yawning, Scratching your head, Drilling your nostrils,***
- ***Digging your ears,*** etc

Environment

- Try to understand their ***mood*** (are they tired, have many problems, feeling sad, is any child sick, mixed feeling etc.)
- Look at ***suitability of topic*** at that moment (talking about child birth with the couple who don't have kids yet etc.)
- Find ***suitable place*** (e.g. quite, not many people around) for the topic you want to discuss. To discuss multi-million dollar business deal, must find a suitable place.
- Find ***suitable environment*** (cold, not smelly, refreshing, clean)

Self-Appearance

- The way you dress
- Cleanliness
- Color of your dress
- Ornaments
- Body smell

Tackling communication challenges in HHs

Some Common Challenges

- **Refusals:** Some individuals may refuse to provide information or allow entry into their HHs
- **Lack of Awareness:** People may be unaware of the importance of the enumeration or expect some pluses
- **Language Barriers:** Differences in dialects or languages can create communication difficulties.

Ways to Overcome

- **Refusals:** Stay calm, show understanding, and share accurate, trusted information.
- **Lack of Awareness:** Use simple, clear messaging and make sure to explain the benefits of the exercise.
- **Language Barriers:** use local language or have a translator assist where one cannot speak

Key Tips for Success

- Always be polite and patient.
- Focus on building a positive relationship rather than achieving immediate results.
- Report challenges to supervisors for further action.

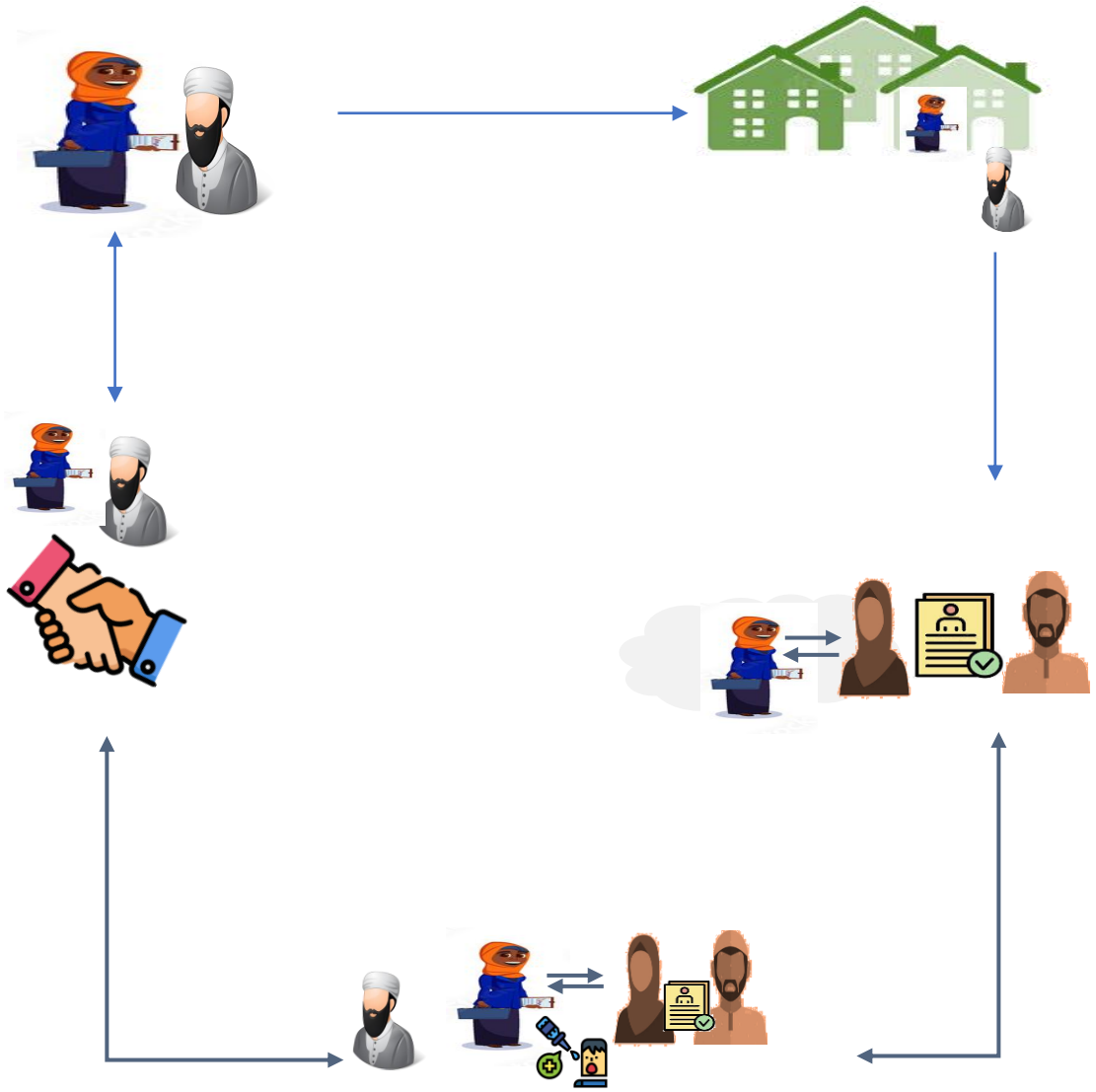
SOURCE: NEOC ACSM Team

Roles and responsibilities of CLs and H2H Mobilisers

Personnel	Key Roles and Responsibilities
 **Community Leader**	▪ Resolution of Noncompliance ▪ Build trust of community members to improve vaccine uptake ▪ Sensitisation of caregivers of Noncompliant HHs on the importance and benefits of vaccination ▪ Provide guidance and leadership to the team ▪ Reporting hard core Non-Compliance to district heads/WFP
 **Team Member/HCWs**	▪ Mobilise/sensitise caregivers on vaccination dates and time ▪ Visit Households for vaccination ▪ Engagement of caregivers on the benefits and importance of vaccination ▪ Target Non-Compliance household and reports unresolved cases to supervisors ▪ Line listing and reporting unresolved Non-Compliance to WFP

Source: ACSM Meeting

Process flow of engagement inside HHs



1. Teams together with Traditional Leader visits HHs with team for vaccination/enumeration
2. Teams engages with caregivers using IPC skills to vaccinate/enumerate eligible child
3. Caregivers gives accurate data / allows for vaccination
4. Teams/Traditional leader thanks caregivers for the time and move to the next house

SOURCE: ACSM Team

Role Play - Scenario 1: *Effective IPC Approach*

1 Approach & Greetings	2 Engaging the Caregivers	3 Providing Key Information	4 *Addressing Concerns*	5 Call to Action & Conclusion
• The Team knocks and enters the household after proper request and permission • Team Greets caregivers respectfully, maintaining a friendly tone. • Calmly ask for the caregivers with eligible children in the HHs	• The Team approaches the caregiver and explains their reason for coming, • The Team asks if they can proceed with the enumeration/vaccination • The caregiver is reluctant to allow enumeration/vaccination for her children	• The Team explains the benefits of the activity, reassuring caregiver about the safety and efficacy /necessity of vaccination/enumeration • They caregivers is convinced and allow for vaccination/enumeration • The Team subtly ask the 5 key questions to ensure no child is missed	*Should a caregiver express concern about the activity, due to past rumors.* • The enumerator calmly counters with facts. • She uses simple language to ensure understanding and shares a relatable success story.	• The Team encourages the caregivers to allow their children to always be vaccinated during campaigns and completes RI • The team thanks them for their time and moves to the next house

Source: ACSM Team

Role play - Scenario 2: *Ineffective IPC Approach*

1 Approach & Greeting	2 Engaging the Caregivers poorly	3 Providing Information ineffectively	4 Failing to Address Concerns:	5 Weak Call to Action & exit
▪ The team uses hard object to knock loudly on the door and then enters the compound without acknowledging the male caregiver	▪ She approaches mother abruptly and demands to speak to her, asking if she has eligible children.	▪ The team rushes through the explanation without ensuring the caregivers understand. ▪ They use technical terms that confuse the caregivers.	• When the caregiver expresses fear of the activity , the team dismisses her concerns instead of explaining. • They fail to build trust and engage the caregiver in convincing conversation with facts ▪ The caregiver refuses to give her child due to the bad mannerism.	• The team ends the conversation abruptly and leaves the house without vaccinating/enumerating the children. • The team proceeds to record and submit the HHs as Noncompliant to WFP

Source: ACSM Team

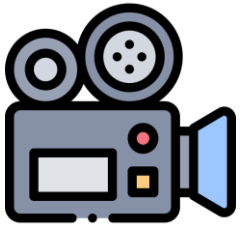
Critique session/link to videos

Critique session guide on role play

Participants analyze both scenarios, discussing:

- What was done correctly in the first scenario.
- What was done incorrectly in the second scenario.
- How the team can improve in real situations.

Link to some IPC Videos



- IPC non-compliant HH training video May 2024.mp4
- IPC Fixed point vaccination training video May24.mp4
- IPC compliant HH training video May24.mp4

Source: ACSM Team

Examples of key messages for different target audience

Key messages for Parents/Caregivers

1	We are vaccinating against the other Polio Variants that is currently circulating in the country
2	The Variant type 2 (cVPV2) of Polio can equally cause paralysis in children if left unvaccinated.
3	The Variant type 2 can be eradicated with just two drops of the polio vaccines at every opportunity.
4	Parents and caregivers can access the polio vaccine at the nearest PHC or during polio campaigns
5	Multiple rounds are essential to ensure every child has been reached and vaccinated to eradicate the virus
6	A healthy-looking child can be a carrier and transmit the disease to an unprotected child, hence the need for all eligible children to be vaccinated

Key messages for NC, FFM, High-risk audiences

1	Multiple doses of the polio vaccine are necessary for complete protection.
2	The oral polio vaccine is safe for both sick children and newborns.
3	The polio vaccine is tested and certified safe by NAFDAC Polio vaccines are stored and transported under appropriate conditions.
4	Polio Virus is still a threat! It paralyses the children! The vaccine is safe, free, and effective.
5	The oral polio vaccine is so safe that it can be given to sick children and newborns.
6	Parents and caregivers, please give consent so that your child can be vaccinated in your absence.

Examples of key messages for different target audience

Key messages for Health care workers/ vaccination teams

1	**Fake finger marking is highly prohibited. However, every non-compliant case MUST be reported for follow-up and resolution.**
2	**The penalty for Fake finger marking is immediate dismissal.**
3	**The target population is not provided for the campaign hence, you are expected to vaccinate ALL eligible children. Note that data falsification may attract sanctions**
4	**Team encourage parents and caregivers to access the polio vaccine at the nearest PHC or during polio campaigns**

Key message for Religious and traditional leaders

1	**Your action matters - be on the side of the children.** Ensure all eligible children (0-59 months) in your community are vaccinated with oral Polio vaccine to protect them against polio paralysis.
2	**Your influence matters.** - Work together with vaccination teams and polio Rapid Response Teams to quickly resolve any case of non-compliance, fake finger-marking or data falsification.
3	**Your action matters - Identify and report any erring team.**
4	**Mobilize/ encourage parents and caregivers in your community, Church or Mosque to access the polio vaccine at the nearest PHC or during the campaigns**

Source: ACSM Team

Reporting ACSM Activities

- **Polio ACSM Planned Activities Form** – completed by **SHEO, LGA HEO, WFP** ONLY
- **Polio ACSM Monitoring Tool** – completed by government & partners (supervisors)

- Both forms domiciled on WHO Partners server
- Server Address:
  - URL – https://api.whonghub.org/partners
  - Username: - partners
  - Password: - partners

Environment

Thanks for your patience, we have covered the following topics:

- ❑ What is Communication
- ❑Interpersonal Communication
- ❑Importance of IPC
- ❑Components of Intrapersonal Communication

Success for US…

… in the polio program requires us to have excellent communication skills!

Thank you

Back-Up

Strategic Shift

- Restructuring of Team Selection From the usual WSC to Independent Partner with the active involvement of Mai-ungwas/District heads (SFPD and Chigari) or relevant associations
- Deployment of CSOs for the timely delivery of activities with quality outcomes in Scope of deployment have been identified (AIT+Kano, Bauchi, Jigawa and Yobe States)
- Door-to- Door initiatives (DOH2H) in Katsina and Sokoto
- Deployment and expansion of NCRTs to high-risk wards
- Active Participation and supervision of Implementing Partners (IPs)

Conclusion

Any Questions?

Thank you

Cold Chain Logistics

STATE CCO/UNICEF VSL

Background

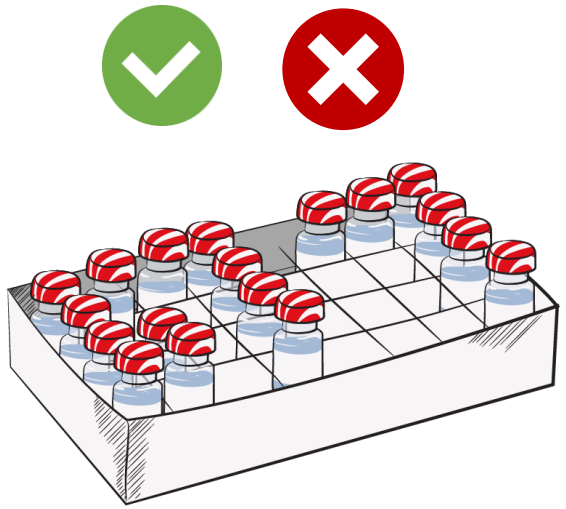
- The efficacy of a vaccine in preventing disease depends largely on the quality of the vaccine
- Failure to adhere strictly to recommended specifications for vaccine handling, storage and distribution can render vaccines useless
- Inactivation of a vaccine may become evident only after immunised individuals acquire the disease the vaccine was designed to prevent
- Studies have reported that improper vaccine storage leading to the administration of sub-potent vaccines may have been associated with outbreaks of vaccine preventable diseases in several developing countries

Cold Chain and Vaccine Management Strategic Shift…1

Focus	Current Situation	Strategic Shift
CCL/VM Dashboard	▪ The National Polio Dashboard encompasses all components of the outbreak responses but not sufficient data on Vaccine Management and logistics.	▪ Post campaign activities in the DB e.g. reverse logistics and waste management for integrated tracking. Also, submission of VAR and Form A reports status and follow up.
The Vaccine Management Ecosystem	▪ Nigeria has a VM system but independent of and not visible at the global CCL/VM platforms.	▪ The ODK questionnaires: There are three ODK forms for vaccine management: the Vaccine Stock Control Tool, the Form A and the Cold Chain Equipment Inventory.

bOPV or nOPV2?

Reminder on the status of the vials



Usable Vials

- The vial has not been opened

AND

- VVM has not reached the discard point

AND

- The label is legible

AND

- The vial is not contaminated

AND

- The expiry date has not passed

Unusable Vials

- The label is unreadable

OR

- The VVM reached the discard point

OR

- The vial is broken

OR

- The expiry date has passed

OR

- The vial is partially used in the previous session/day or empty

General Reminders: Multi Dose Vial Policy

It is **not recommended** to **implement MDVP in nOPV2 campaigns**

1. It is **difficult to ensure** that the nOPV2 vials continue to be kept at the **recommended temperatures after opening** because of the possibility of substandard vaccine carriers and the inability of VVMs to reflect short, high-temperature exposures.

2. Keeping open vials **free of contamination** in a house-to-house campaign is **nearly impossible**.

3. Because nOPV2 use **requires 100% accuracy** in vaccine accountability records, MDVP implementation **would reduce the precision** of accountability reporting since it would not be possible to accurately count the leftover doses in opened vials at the end of the day.

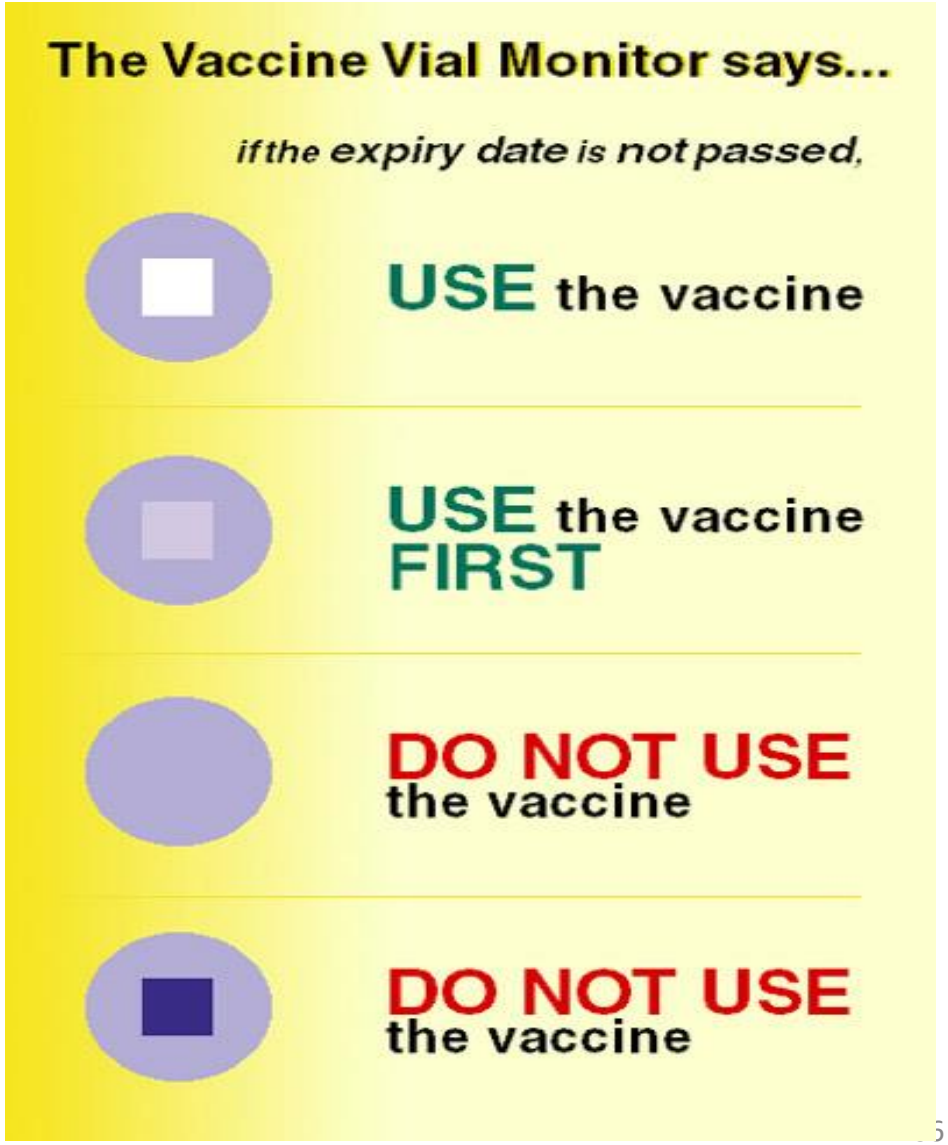
Although preventing vaccine wastage is important, maintaining full accountability for a vaccine under containment, such as nOPV2, is imperative for the GPEI.

Vaccine Vial Monitor (VVM)

- VVM of liquid vaccines is present on the vial sticker
- The VVM of reconstituted vaccines is present on the cap (Measles, BCG, YF, several formulations of Hib)

How does it work?

- VVM shows cumulated exposure to heat



Reverse Logistics

- nOPV2 unused vials may be needed for mop up activities or for another SIA ➔ *maintain highest quality of storage*
- Reverse logistics should meet the same standards applied to nOPV2 distribution.
- Since nOPV2 is not damaged by repeated freezing and thawing, storage in a freezer will extend its life time.
- Upon return of the vaccine at central level, the store manager needs to check the vials:
    - VVM status
    - Are the labels still readable
    - Any sign of damage that may have compromised the quality of the vaccine inside.
- Any vial not meeting the standards should be disposed of after correction of the stock records.

Why should we ensure a safe disposal of nOPV2?

Oral Polio vaccine (OPV) is a **LIVE VIRAL VACCINE**, and OPV type 2 is **under containment since 2016**.

Unusable Vials (Empty , partially used / broken vials) should be

- **Properly managed** (not left in routine vaccine system) but **destroyed** using standard SOPs
- **Aggregated** at pre-identified site and **accounted** for further management and destruction once Outbreak is closed by OBRA.

Before the Campaign

- **Map the waste management/disposal sites (with recommended options)**
  - Within the health system (health facilities/Hospital..) and/or
  - Out of the heath system, (building Partnership with private settings..)
- **Cluster HF to identified reference site**
  - Collection from facilities/districts to identified reference treatment/disposal sites
- **Define the accountability framework**
  - Who is responsible of What: handling/transportation/waste management/disposal, supervision… reporting)
- **Provide and train on SOPs of handling, storage and disposal of nOPV2 as well as on accountability**
- **Elaborate the budget for disposal implementation within the outbreak response budget**:
  - Identified disposal sites (Service cost/ new equipment/repair/maintenance/Protective equipment/product… , sealable bags..)
  - Transportation cost /adequate transportation means (direct transportation /loop transportation):

During the Campaign (1/2)

Daily tracking of all unusable vials (fully or partially used)

At the end of the campaign day, health store/distribution points/subdistrict/district… **received and count all unusable vials** (fully or partially used) and **update the vaccine monitoring form.**

Bad practice

Good practice

During the Campaign (2/2)

Some challenges during the pre-collection of unusable nOPV2 vials

Mixed with vials of other vaccines

Vials with labels mutilated (?)

After the Campaign (1/5)

Safe collection of unusable nOPV2 vials after each round

- ❑ All unusable vials should be retrieved within 5 days of completion of the round.
- ❑ All unusable vials should be counted, and quantities reported to the national level within 7 days (using the standard form A).
- ❑ All unusable vials should be inactivated and safely disposed in compliance with the GPEI or national guidelines and regulations for heath care waste management

Unusable nOPV2 vials, packed and sealed for collection to the disposal sites

After the Campaign (2/5)

Safe collection of unusable nOPV2 vials after each round (cont.)

- **Decision to dispose** the remaining stocks of usable nOPV2 vials should be taken.
- All usable nOPV2 vials should be counted and quantities reported to the national level within 7 days (using the standard form A).
- The National Logistic Working Group (NLWG) should collate all form A from the lower levels and summarize into a national form A to be transmitted to UNICEF CO for onward transmission to UNICEF/HQ within 14 days.
- All usable vials should be inactivated and safely disposed in compliance with the GPEI or national guidelines and regulations for heath care waste management
- Ensure the accountability and final disposal reports are shared with National Polio Containment Coordinator for inclusion in the annual National Certification Committee report.

After the Campaign (3/5)

Inactivation methods

Boiling : Immersion of vials in **boiling water** for at **least 30 mn**

Cross section of used MOPV2 vials at the boiling point inside the drum being monitored

State VSL and Hard hawk workers monitoring the level of fire and vials inside the drum

Adamawa State

After the Campaign (4/5)

Inactivation methods

Incineration: Carried at a **temperature >1100◦C.**
Ash must be treated as toxic waste and disposed accordingly

High temperature Incinerator in a hospital

High temperature furnace in a factory with pollution control

After the Campaign (5/5)

Inactivation methods

Incineration at **low (<800C)and medium (800-1100C)** temperature are **NOT SAFE** options

Example of medium temperature incinerator

Examples of low temperature incinerators

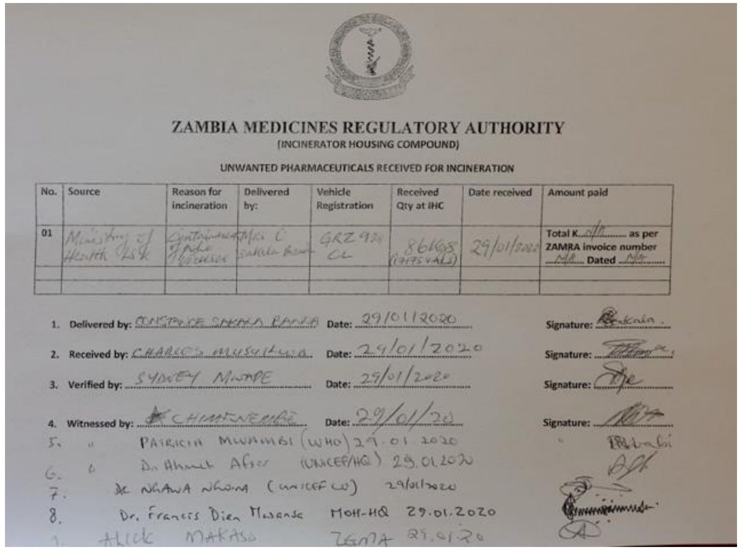
Note that Low and medium temperature are not recommended because they cause hazards to the environment

Flow-Map – Waste Disposal

Selection of the disposal facility

Disposal (incineration)

Report preparation



ZAMBIA MEDICINES REGULATORY AUTHORITY
(INCINERATOR HOUSING COMPOUND)

UNWANTED PHARMACEUTICALS RECEIVED FOR INCINERATION

No.	Source	Reason for incineration	Delivered by:	Vehicle Registration	Received Qty at IHC	Date received	Amount paid
01	Ministry of Health [illegible]	[illegible]	[illegible]	GRZ [illegible] CL	86[illegible] ([illegible] VIALS)	29/01/2020	Total K..n/a.... as per ZAMRA invoice number ..NA.. Dated ..NA..

1. Delivered by: [illegible] Date: 29/01/2020 Signature: [illegible]
2. Received by: CHARLES MUSUKWA Date: 29/01/2020 Signature: [illegible]
3. Verified by: SYDNEY MWAPE Date: 29/01/2020 Signature: [illegible]
4. Witnessed by: CHIMAZWEMBE Date: 29/01/20 Signature: [illegible]
5. " PATRICIA MWAMBI (WHO) 29.01.2020
6. " Dr Ahmed Afser (UNICEF/HQ) 29.01.2020
7. Dr NGAWA NGOMA (UNICEF CO) 29/01/2020
8. Dr. Francis Dien Mwansa MOH-HQ 29.01.2020
9. ALICK MAKASO ZAMRA 29.01.20

The report

Disposal

Incineration was the most preferred method for disposal. A report with the actual number of vials disposed of needs to be reported to GPEI.

After the Campaign

Disposal of nOPV2 should be reported properly

- **Examples of reports:**

REPUBLIQUE DEMOCRATIQUE DU CONGO
MINISTERE DE LA SANTE PUBLIQUE
PEV

FICHE DE TRANSFERT DES DECHETS VERS LE SITE D'INCINERATION

DATE: 12/06/2018

Province Hte KATANGA Zone de Santé ANT. LIKASI Aire de Santé

Site de destruction USINE DE RUBAMIN

Nombre de flacons non entamés	Flacons entamés	Nb flacons vides +Entamés	PCV virée	Cassés	Total flacon à detruire
8365		78 452	632	54	87 503

Pour la Zone de santé
Nom et Prénom du MCZ
Date ___/___/201___
Signature

Pour le Transfert
Nom et Prénom du Convoyeur M MUTEBA CHIWAMBU
Date 12/06/2018
Signature

Pour le Site d'incinération
Nom et Prénom du Responsable ELIE MWINKEU BA
Date 12/06/2018
Signature

Nb: Cette fiche sert d'ordre de mission et de [illegible]. La fiche doit être signée en trois exemplaires. Une copie reste au site d'incinération, une copie est gardée par le convoyeur et une copie est retournée à la ZS/Antenne

mOPV2 Disposal Report

Date of disposal : ___/___/_____

Site / Location of disposal:_____

Disposal method	
Inactivation	**Destruction**
☐ Boiling ☐ Chemical inactivation ☐ Autoclaving ☐ Other (please explain):	☐ Incineration ☐ Encapsulation ☐ Burying ☐ Other (please explain):

Number of mOPV2 vials disposed of		
Opened vials	**Unopened vials**	**Total**

Remarks

Disposal Team:

Name	Position	Signature

CCE Update: Vaccine Carriers Distribution Plan

SN		Vaccine Carrier (Blowkings)
1	Abia	400
2	Adamawa	450
3	Akwa Ibom	550
4	Anambra	500
5	Bauchi	600
6	Bayelsa	225
7	Benue	500
8	Borno	500
9	Cross River	400
10	Delta	500
11	Ebonyi	300
12	Edo	400
13	Ekiti	350
14	Enugu	465
15	FCT	210
16	Gombe	500
17	Imo	500
18	Jigawa	800
19	Kaduna	900
20	Kano	1,500
21	Katsina	1,000
22	Kebbi	800
23	Kogi	450
24	Kwara	350
25	Lagos	850
26	Nasarawa	350
27	Niger	600
28	Ogun	500
29	Ondo	400
30	Osun	400
31	Oyo	400
32	Plateau	450
33	Rivers	500
34	Sokoto	750
35	Taraba	500
36	Yobe	550
37	Zamfara	600
	Total	**20,000**

THANK YOU

Implementation of High-Risk Operational Plan

WHO SO/APHO

Outline

- Overview of the High-risk operational plan (HROP)
- Gaps in HROP development and implementation
- Implementation of the HROPs Plan, what do we do differently
- Monitoring the implementation of the HROP

Overview of the High-risk operational plan (HROP)

The HROP is developed at ward, LGA and state level using the findings of the High-risk analysis

Objectives

- To develop high-quality operational plan specific for each of the risks identified in the HRA result.
- To achieve High Quality implementation necessary for interruption of cVPV2 by December 2025

Overview of the High-risk operational plan (HROP)

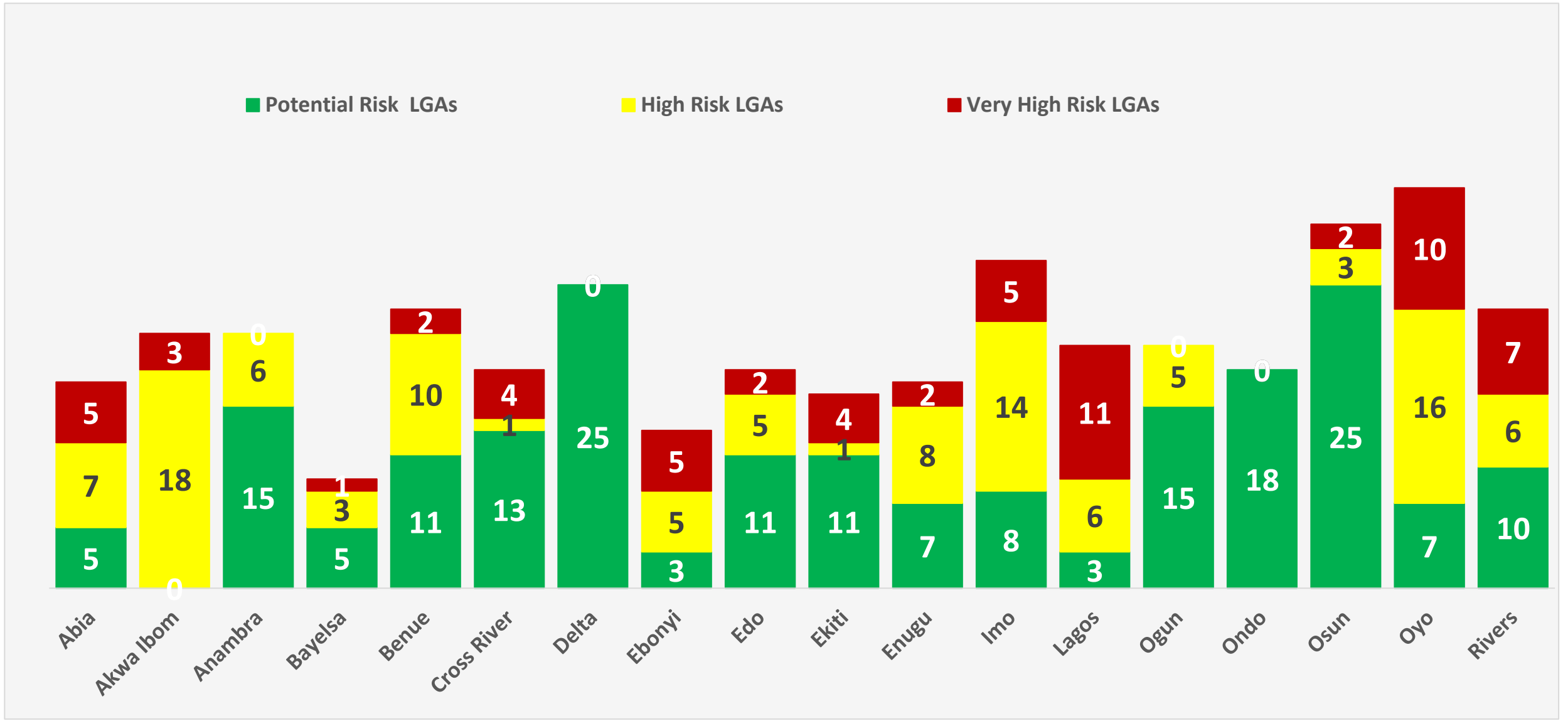
Who is involved in HROP development?

- WFPs
- Chairman social Mobilization Committee
- Partners in the LGA
- DSNO
- LIO
- LGA Health Educator
- LGA PHC Director

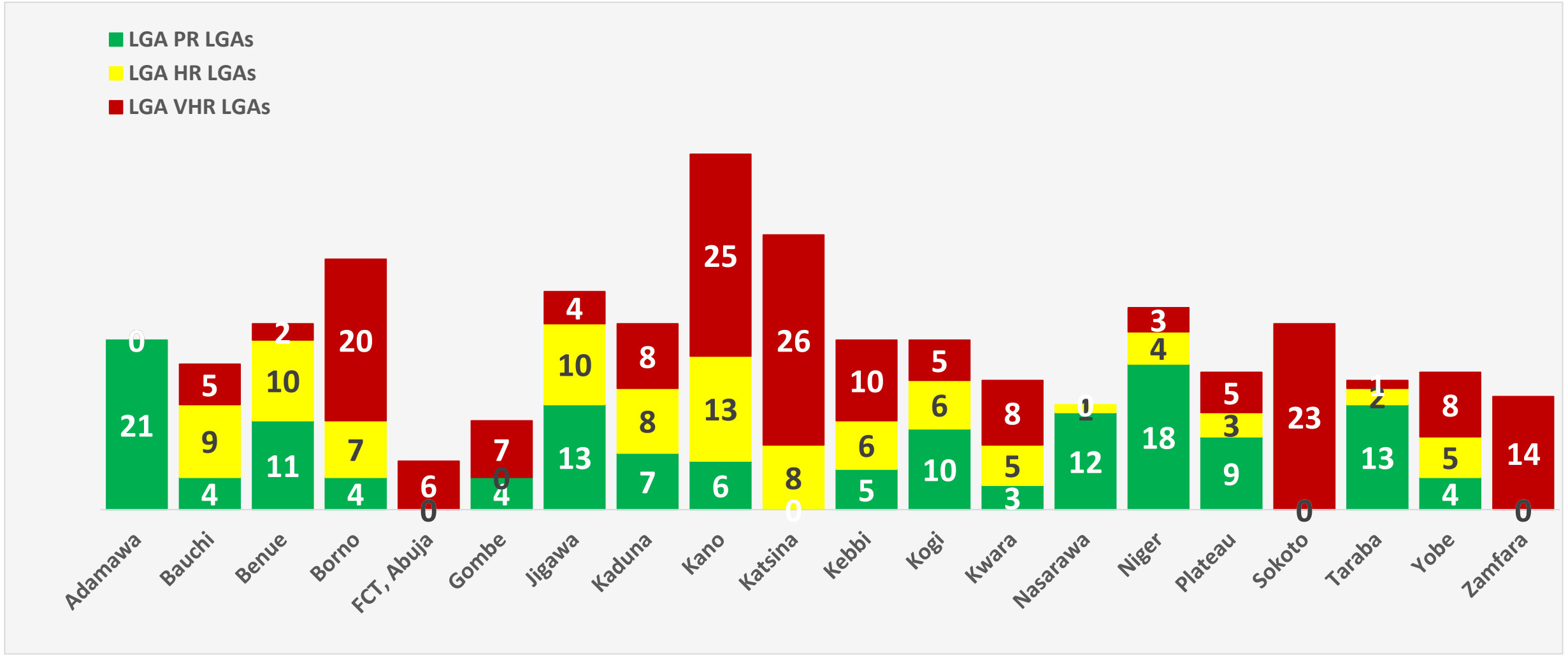
- The HROP is developed at ward, LGA and state level following the High-risk analysis
- The high-risk analysis (HRA) scope
  - ✓Epidemiology & AFP Surveillance
  - ✓SIA indicators
  - ✓Routine Immunization indicators
  - ✓Geographical and Demographic issues
  - ✓ Accessibility & Security issues

  Risk analysis of States_April 25 NIPDs (2).xlsx

Overview of the High-risk operational plan (HROP)
Risk status of Southern state , March 2025



Overview of the High-risk operational plan (HROP)
Risk status of Northern state , March 2025



Steps to develop HR Operational Plan

Step 1. conduct High Risk Analysis using HRA template to Identify Very and High Risk LGA/Ward/settlements

Step 2. **Set objectives, activities and expected outputs to be conducted for each thematic area:** *Based on the problems and gaps identified make out specific activity to address the gaps*

Step 3. **Identify the cause of the specific problems per LGA/Ward/Settlement:** This will bring out the various reasons for the identified problem in a settlement/Ward/LGA.

Step 4. **Identify set of intervention / activities to be conducted within the thematic areas in line with the identified gaps**

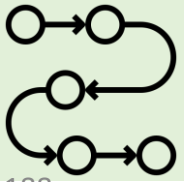
Step 5. **Establish time frame**

Step 6. **Identify indicators:**

Step 7. **Identify Responsible Person**

Step 8. **Determine Budget**

Step 9. **Status of implementation of activities report:**



Gaps in HROP development and implementation (1/2)

- Use of wrong HRA_HROP template.
- Poor-participation of program officers (DSNO, HE, LIO, RIOs, M$E, DPHC) at the LGA level during development of HRA_HROP
- Most of activities plan are tailored to address the critical issues identified in high-risk analysis.
- The social mobilization component (Community dialogues, sensitization, RRT, Announcements etc) not factored in ACSM plan for funding

Gaps in HROP development and implementation (2/2)

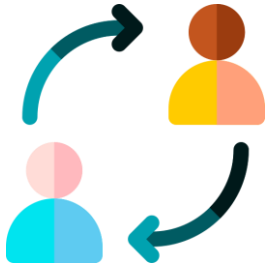
- The surveillance activities (retro-active case search etc) not captured in the SIP.
- Routine immunization activities (Addressing the high DoR, Un-immunization) not properly plan with RI team.
- Poor review of HRA_HROP during EOC meeting.
- Non-use of other funds available to address issues.
- LGAs develop HRA_HROP just to tick a box.

Implementation of the HROPs Plan, what do we do differently

- Use of correct HRA_HROP template.
- Mandatory Participation of program officers (***DSNO, HE, LIO, RIOs, M$E, DPHC***) at the LGA level during development of HRA_HROP
- Activities plan are tailored to address the critical issues identified in high-risk analysis
- Planned activities must be **SMART** (Specific, Measurable, Achievable, Relevant, and Time-bound)
- Social mobilization component (Community dialogues, sensitization, RRT, Announcements etc.) needs to be factored in ACSM plan for funding.
- Surveillance activities (retro-active case search etc.) in HROP must align with SIP.

Implementation of the HROPs Plan, what do we do differently

1. Routine immunization activities (Addressing the high DoR, Un-immunization) not properly plan with RI team.
2. The EOC need to review the HRA_HROP during EOC meeting properly to ensure activities are tailored to address the issues, incase of inadequate funding to look for additional funds.
3. Use of other funds available to address issues.
4. Track the implementation of HRA_HROP



Monitoring, the implementation of the HROP implementation

LGA	No of HR Wards	Critical Issues (Include data)	Activity/scope	Time frame	Process Indicator	Expected Outcome	Person Responsible	Status of immplementation

Key Action Point

States specific ***HROP*** *and* ***risk status*** *to be present during training at all levels*

- ***State***
- ***LGA***
- ***Ward and***
- ***Settlement***
- ***Household***

to guide implementation during the campaign

THANK YOU

Data Tools & Management

STATE M&E, DR. MAKIO, JAMES OKO

Outline

1. Key Changes on Data Management
2. Key data tools & forms expected from the field
3. Pre-Campaign Dashboard
4. Data Quality Issues
5. Practical Session (Commcare/e-tally/PCDB)

Source: Team analysis

Key Changes on Data Management

Focus areas	Key Change
Data Collection	▪ Deployment of **e-Tally** – filling is **COMPULSORY** ▪ **E-Tally to be used in all states except those conducting IEV** ▪ E-tally does not REPLACE the paper tally sheet
Data Sets & Tools	▪ Harmonized **Master List of Settlements** to be used as baseline for microplanning ▪ **Deployment of Ward-Level Microplan Template**
Analysis Plan	▪ Adopt the new **analysis plan** to be shared by the NEOC data working group for harmonized analytical outcomes ▪ Standardized Evening Review Meeting & Post-Campaign **Reporting Templates** to be used by state teams
PCDB	▪ Revised & harmonized **pre-campaign dashboard**
ODK Tools	▪ Prompt filling of all **recommended checklists** from the WHO partner server by field teams/supervisors

Others

- Team Recorder must possess a **functional android phone**
  - **e-Tally** forms to be redownloaded from **3 days** to the campaign
  - Android devices should be set on automatic updates
- **VTC sessions** will be conducted to guide state data teams on the **analysis plan** & **new pre-campaign dashboard visualization** (Tableau)
- **Capacity building** sessions schedules will be shared with state data teams for implementation
- A printed **ward-level microplan template,** pre-filled with the lists of settlements for each ward is recommended

Overview of the Changes on the Pre-Campaign Dashboard

National	State Level		LGA Level	
Current (newly developed & adopted) (46)	Original (23)	→ Current (46)	Original (38)	→ Current (48)

Thematic Areas	
Planning & Coordination	Training
Monitoring & Supervision	Vaccines, Cold Chain & Logistics
ACSM	Microplanning & Funding

Timelines	Scoring
6 weeks – 1 week 3 days 1 day	**Old:** (Yes/No) **New:** (Done, not done & partially done)

The major changes in numbers resulted from unbundling compound indicators, addition of critical indicators and harmonizing the Nigerian indicators with that of AFRO

SOURCE: Team Analysis

Guidelines - key persons responsible for updating the PCDB indicators

		All levels (National, State & LGA) As it applies to you
National Level	• Responsible: **NEOC M&A Officer** • Supported by: As assigned by IM/DIM • Supervised by: **National IM/DIM**	**6 weeks – 1 week, 3 days & 1 day** • **Reviewed daily, filled as at when due** • **8:00am, 12:00noon & 4:00pm**
State & LGA Level	• Responsible: **State Immunization Officer** • Supported by: As assigned by SIO/IM • Supervised by: **IM/SIO, WHO SC, UNICEF SL** • **Accountable Officer: NPHCDA State Coordinator**	

SOURCE: Team Analysis

Overview of the SOP for e-tally

Requirements

- At least one member of the team preferably the **recorder** (team supervisors) should have a **functional android phone** and the ability to use the android phone effectively.
- Both the ODK and the traditional method of the Tally Sheet data collection process will be use.

Responsible Person

- The **recorder** (team supervisor) is responsible for both the manual and ODK Tally Sheet collection for **H2H, DOPV Teams, Fixed Post, Special Teams, Transit teams etc**
- Ward Focal Person is responsible for the Summary of the Manual/paper tally sheet collection and summarizing.
- Team Supervisor/Ward Focal Person are responsible for ensuring that the **ODK is Install** before training/commencement of the campaign exercise [**Download e-tally form from the partner server – "OPV e-Tally Summary (State Name)"**]
- MSTs/State and LGA Supervisors deployed should always **remind the vaccination recorder (team supervisor)** to submit their completed e-tally sheet at the **end of each settlement covered** and Fixed Post conducted at the end of each day's work.

Timelines

- Each team **(H2H, Special team, DOPV Team)** is expected to capture the Tally Sheet data using the ODK and **submit immediately** at the end of vaccination in **each settlement before moving to the next settlement. (Even if it takes a team a whole day or more to finish a settlement).**
- All completed Settlement ODK e-Tally Sheet data should be submitted by **3 pm** on a daily basis so that it can be analyzed for feedback during evening review meetings both at the state and national levels.

SOURCE: Team Analysis

Key data tools & forms expected from the field

Expected Data at National level

1 Pre-Implementation

Expected data:

1. 3, 2, 1 week & 3 days Pre-Campaign Dashboard (Google Sheet)
2. Updated Master List of Settlements
3. Micro Planning & Daily Implementation Plan
4. Polio ACSM Monitoring Tool
5. **Pre-Implementation Checklist**
6. Training Monitoring Checklist

2 Implementation

Expected data:

1. **e-Tally ODK**
2. Daily Call-In Data by LGA (google sheet)
3. Intra-Campaign DB data (Google Sheet)
4. EIM In-Process inside/Outside Household Monitoring (ODK based)
5. **Supportive Supervision by MST/Senior Supervisors(ODK based)**
6. Polio ACSM Monitoring Tool
7. Data Quality Checklist

3 Post-Implementation

Expected data:

1. Ward summary admin tally/vaccines (Access DB)
2. Insecure Settlements Vaccination Tracking (Excel)
3. EIM End-Process inside/Outside Household Monitoring (ODK based)
4. Post_Campaign_VALIDATION Insecure Settlement (ODK based)
5. LQAS data (ODK based)
6. Social Mobilization Indicators
7. Post-Implementation Checklist (ODK based)
8. NC & CA Validation Checklist

Frequency of filling Pre-Campaign Checklists – 3, 2, 1 weeks & 3 days
Polio ACSM Monitoring Tool – Pre, Intra & Post campaign

Source: Team analysis

Challenges Encountered and Recommendations

Focus areas	Challenges/Issues	Recommendations
Pre-Campaign	▪ Lack of synergy between PCDB and the reality on ground	▪ Activities should be validated before being updated on the PCDB
	▪ **Sub-optimal training** on data tools and ODK checklists at the lower levels	▪ Ensure lower-level trainings includes a dedicated session on data tools and management
	▪ **Sub-optimal training** on data tools and ODK checklists at the lower levels	▪ Ensure lower-level trainings includes a dedicated session on data tools and management
Intra-Campaign	▪ **Late submission** of call-in data and e-tally ▪ **Poor utilization** of e-tally ODK lists ▪ Utilizing **older versions** of e-tally & MST ODK checklists ▪ Data panel beating (**falsification**)	▪ Submission of call-in data by 3pm & e-tally immediately after completion of each settlement ▪ Ensure the most recent versions of the e-tally and MSTs checklists are used during campaigns ▪ All forms of data falsification should be discouraged ▪ MSTs to fill Data Quality Checklist
Post-Campaign	▪ Delayed submission of tally sheet analysis data	▪ Ward-level tally sheet summary to be submitted 6 days after day-2 of mop-up

Team members are advised to desist from the following actions to ensure a successful campaign implementation

DON'T

- **Falsification of data!!!!!**
- Use of tracker phones for taking pictures
- **Fake finger marking of children!!!**
- Lateness to work venue/take off point

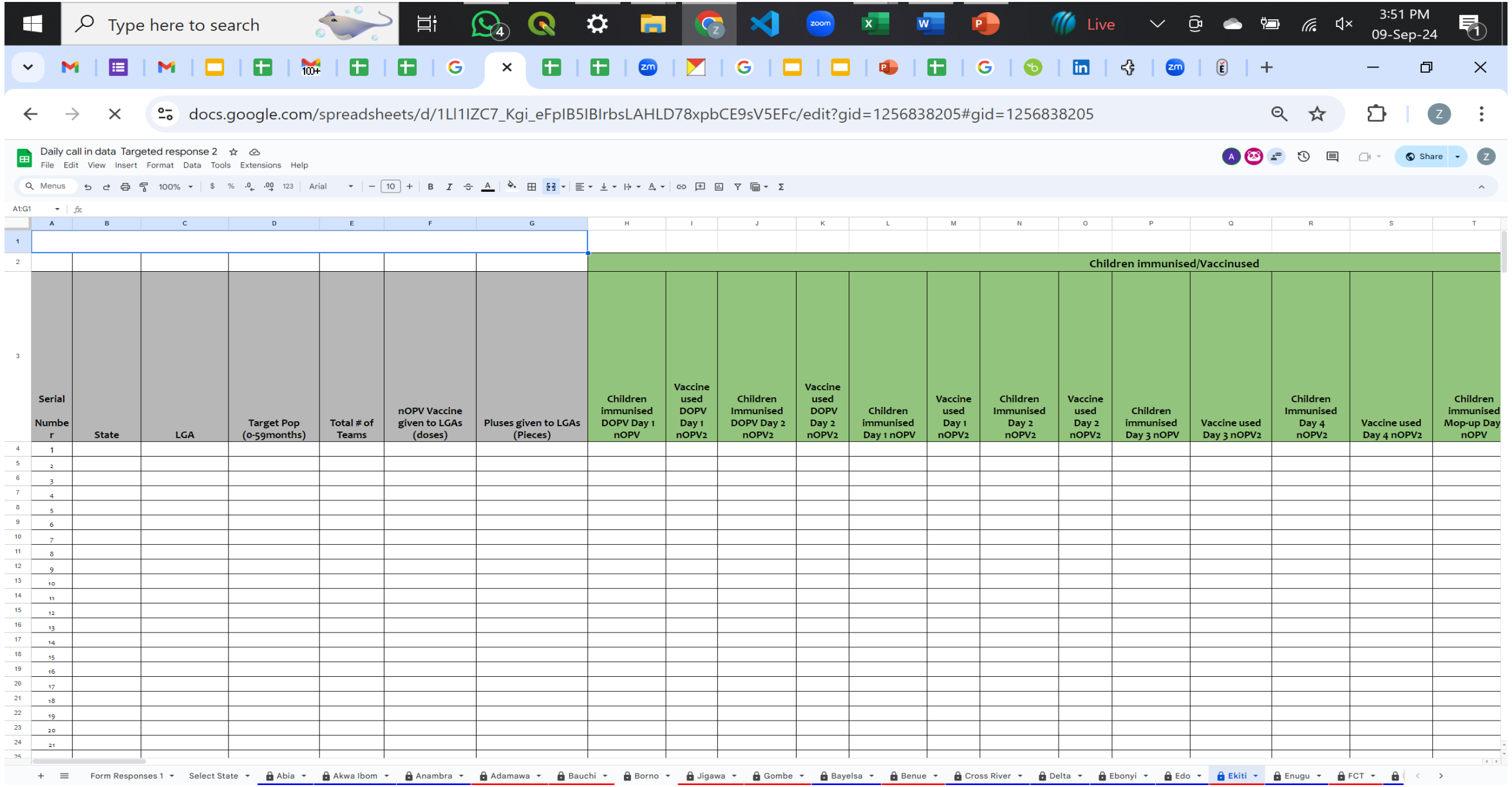
- During previous SIA rounds, it was observed that certain vaccination teams had engaged in inappropriate practices
- Any vaccination team found to be taking any of these actions will be immediately **suspended from working** and may face further **disciplinary actions** from the state

Source: NEOC team analysis

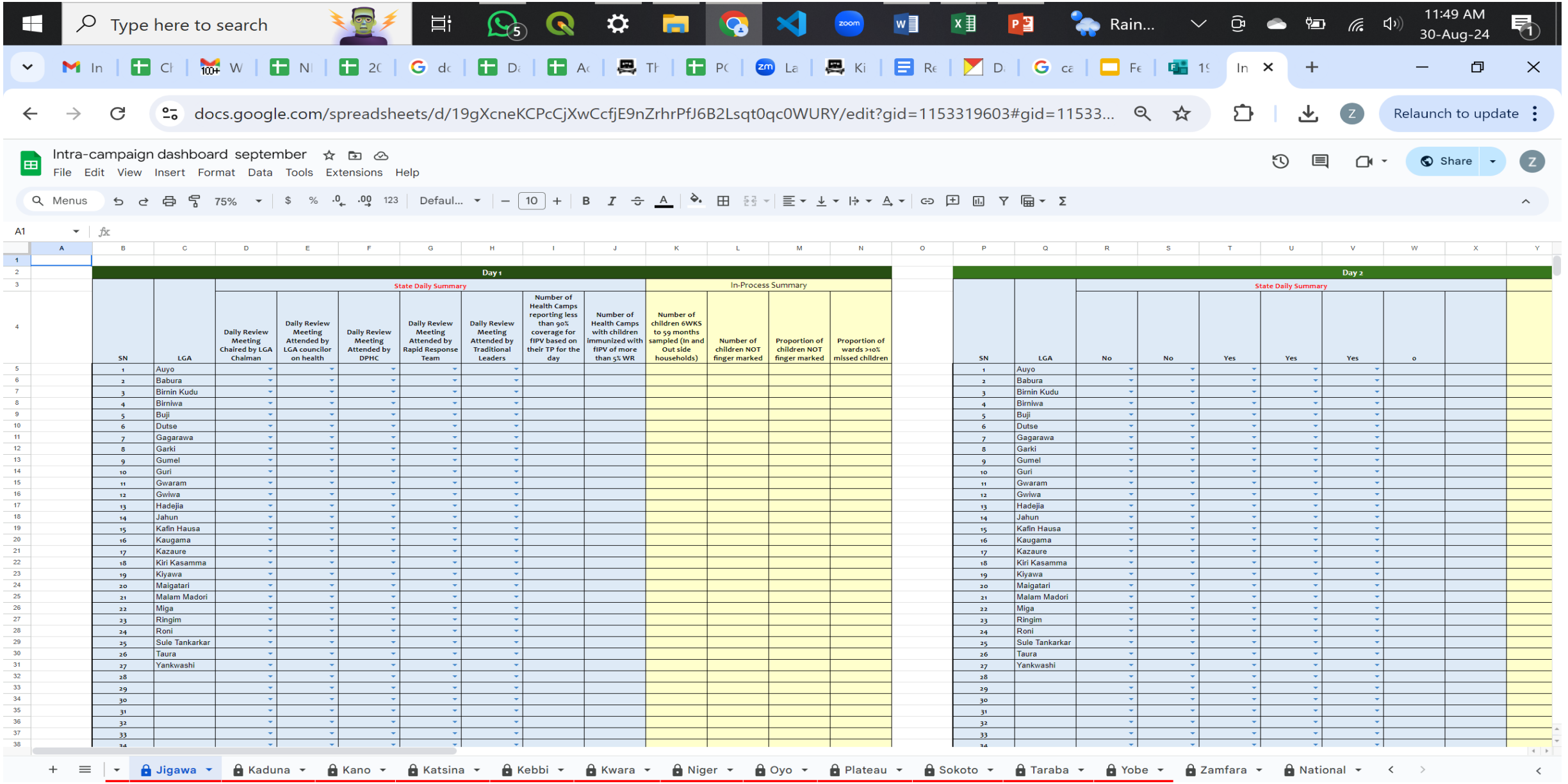
Practical Demo on e-tally

Thank you

Call in data and intra-campaign dashboard



Sample of the Call in data and intra-campaign dashboard



Intra-campaign dashboard september

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			Day 1												Day 2								
			State Daily Summary							In-Process Summary					State Daily Summary							
	SN	LGA	Daily Review Meeting Chaired by LGA Chairman	Daily Review Meeting Attended by LGA councilor on health	Daily Review Meeting Attended by DPHC	Daily Review Meeting Attended by Rapid Response Team	Daily Review Meeting Attended by Traditional Leaders	Number of Health Camps reporting less than 90% coverage for fIPV based on their TP for the day	Number of Health Camps with children immunized with fIPV of more than 5% WR	Number of children 6WKS to 59 months sampled (In and Out side households)	Number of children NOT finger marked	Proportion of children NOT finger marked	Proportion of wards >10% missed children		SN	LGA	No	No	Yes	Yes	Yes	o		
5	1	Auyo													1	Auyo							
6	2	Babura													2	Babura							
7	3	Birnin Kudu													3	Birnin Kudu							
8	4	Birniwa													4	Birniwa							
9	5	Buji													5	Buji							
10	6	Dutse													6	Dutse							
11	7	Gagarawa													7	Gagarawa							
12	8	Garki													8	Garki							
13	9	Gumel													9	Gumel							
14	10	Guri													10	Guri							
15	11	Gwaram													11	Gwaram							
16	12	Gwiwa													12	Gwiwa							
17	13	Hadejia													13	Hadejia							
18	14	Jahun													14	Jahun							
19	15	Kafin Hausa													15	Kafin Hausa							
20	16	Kaugama													16	Kaugama							
21	17	Kazaure													17	Kazaure							
22	18	Kiri Kasamma													18	Kiri Kasamma							
23	19	Kiyawa													19	Kiyawa							
24	20	Maigatari													20	Maigatari							
25	21	Malam Madori													21	Malam Madori							
26	22	Miga													22	Miga							
27	23	Ringim													23	Ringim							
28	24	Roni													24	Roni							
29	25	Sule Tankarkar													25	Sule Tankarkar							
30	26	Taura													26	Taura							
31	27	Yankwashi													27	Yankwashi							
32	28														28								
33	29														29								
34	30														30								
35	31														31								
36	32														32								
37	33														33								
38	34														34								

Jigawa | Kaduna | Kano | Katsina | Kebbi | Kwara | Niger | Oyo | Plateau | Sokoto | Taraba | Yobe | Zamfara | National

Thank you

Monitoring and Supervision

WHO IDSR FP

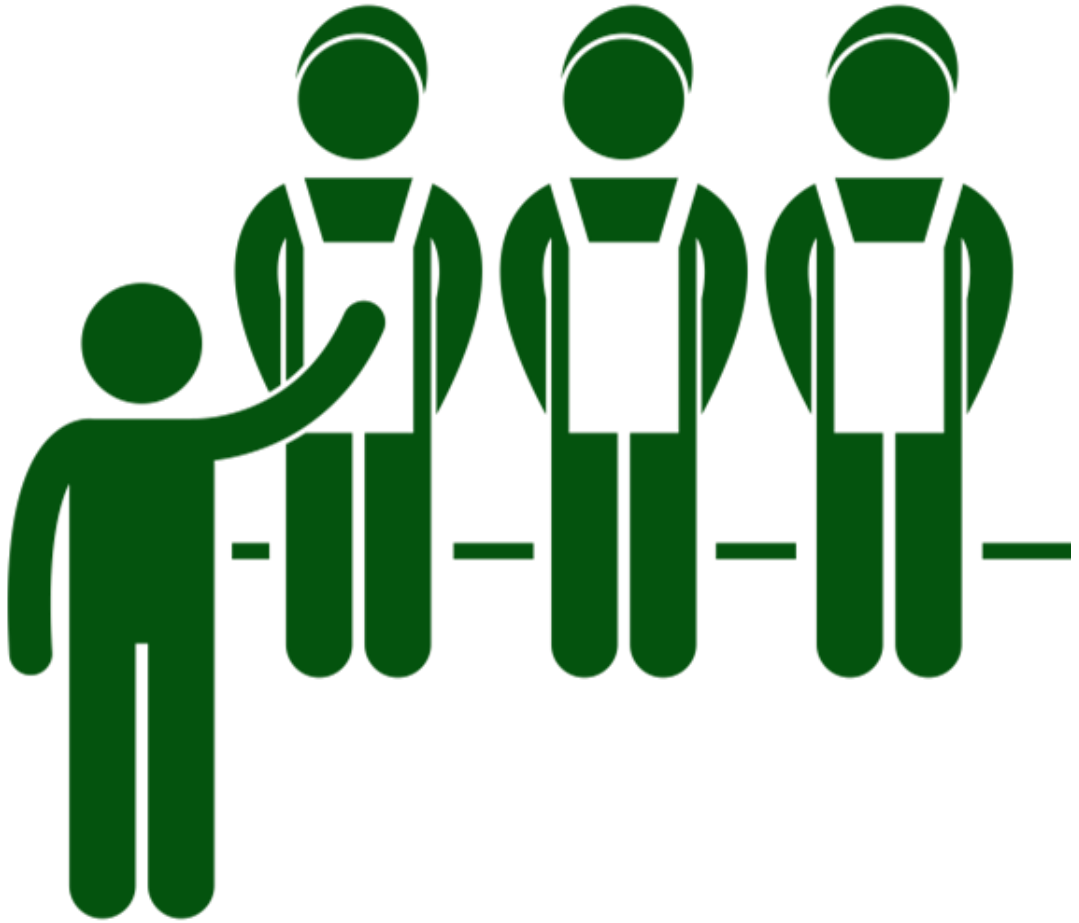
Overview

- Define supervision
- Objectives of supervision
- Describing supervisors and supervisory levels
- Phases of supervision
- Roles of supervisors at different phases
- Supervisory tools and additional supervisory layer
- Evening review meetings
- Conclusion

Supportive Supervision

- It is a process of **helping personnel** to **improve** their own work performance continuously

- It involves observing, collecting data and **making decisions** to **guide** and **support** personnel for **quality implementation** of any program



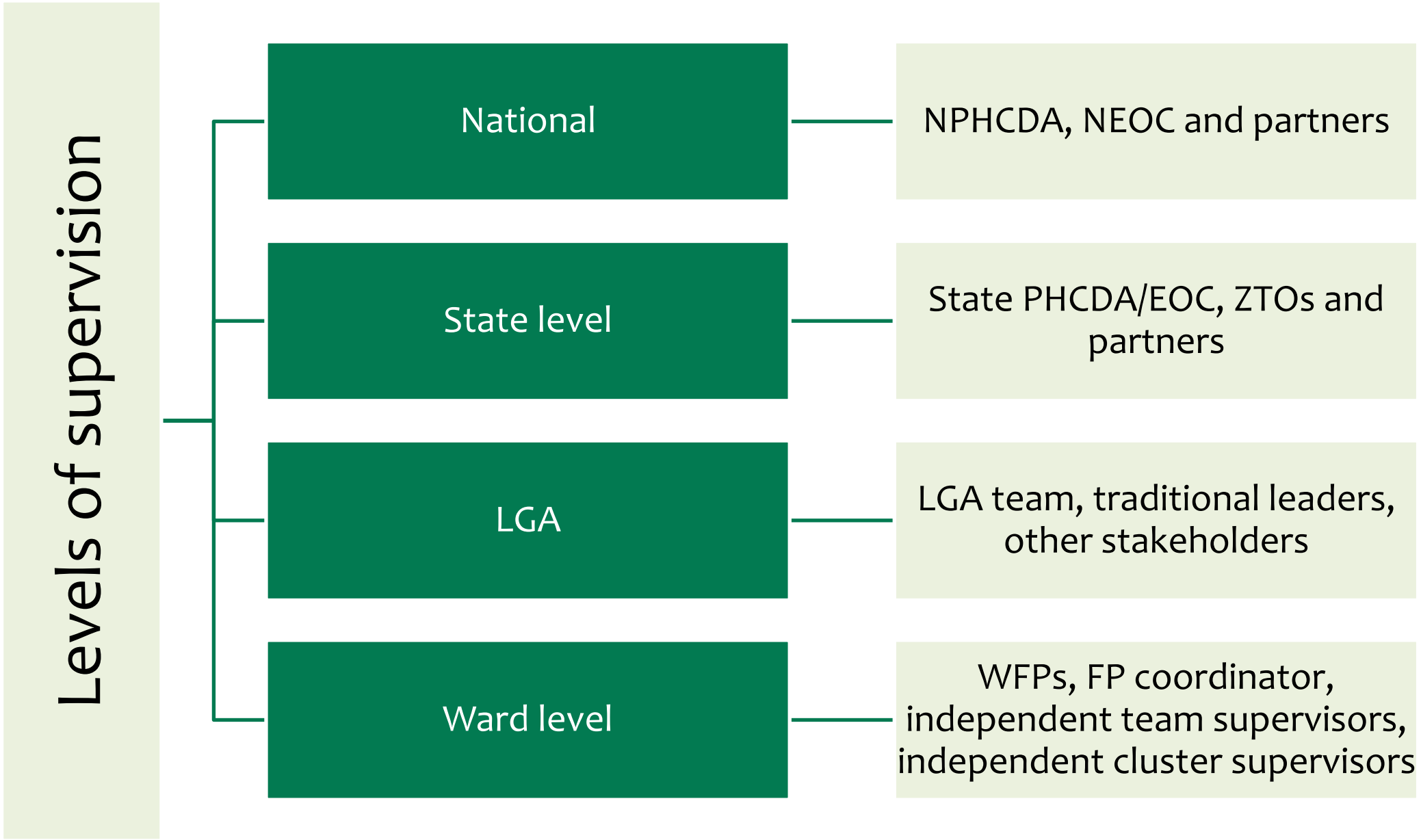
Objectives of Supervision

- To facilitate **teamwork** and provide **leadership** and **support** to empower the teams improve their own performance
- To **correct** and **improve performance** so that activities become more focused, more effective & efficient
- To **promote quality** outcomes by feedback, focusing on problem-solving

Objectives of Supervision

Who are these Supervisors?

Supervisory Levels

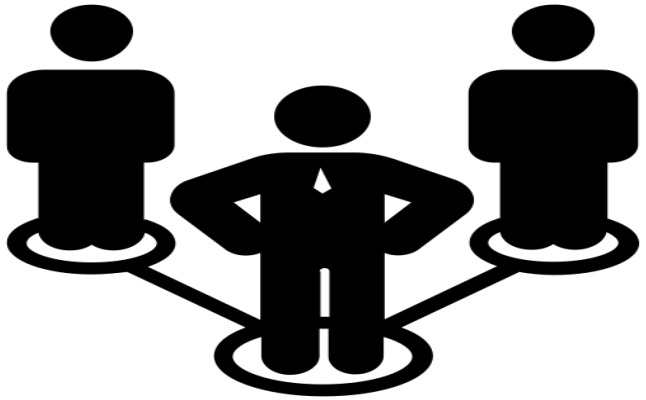


National Level Supervisors

- Government and partners
- They conduct **regular supervision** of pre, intra and post-implementation activities from the state to LGA levels using the **standardized checklist**

State Level Supervisors

- Representatives from line ministries & **state-based partner** agencies
- It should also draw membership from state chapters of various associations/**CBOs** (Guild of Private Medical Directors, FOMWAN, CAN, NCWS)
- State supervisors should also be members of **State Task Force on Immunization** (TFI) & the State Technical Team



LGA Level Supervisors

- Government & partner agencies at the LGA level
- They are involved in **daily SIAs supervision**
- Participate in daily evening review meetings **(ERM)** chaired by LG Chairman, to discuss findings & data from the field
- LGA **supervisory plans** are drawn up at this level

Ward Level Supervisors

- Senior health personnel who act as Ward Focal Persons and Underserved/Special Populations Supervisor

- Coordinate all supervisory activities at the ward level even in hard-to-reach areas

Phases of supervision ...1

1. Pre-implementation phase

- The most crucial phase of the campaign
- The goal is to ensure that plans are complete, gaps are identified, and corrective intervention are taken at the earliest possible time to ensure a high-quality campaign
- Activity here starts **6 weeks at the national level before implementation and 5 weeks at both state & LGA level**

2. Implementation phase

- The goal is to ensure that planned activities are conducted with high quality
- The supervisory activities here include:
  - Supervision of vaccination teams to ensure eligible children get the right antigen(s)
  - Attending and providing feedback at evening review meetings at the Ward, LGA and State levels
  - Resolution of noncompliance and some sort of advocacy are still undertaken at this phase

Phases of supervision ...2

3. Post implementation phase

- The **goal** is to **evaluate work done** during the implementation phase for the purpose of future decision making
- MST/Supervisor may have limited roles during this phase
- Supervisor can however follow up on NC resolution, revisit for child absent and guide on areas for mop-up based on IM data and daily call in data on settlements not covered or improperly covered

Pre-implementation activities …1

Level	Major Activities	Responsible
National	Planning meeting	National EOC
	▪ Vaccine, cold chain and logistics ▪ Advocacy, social mobilization and communication ▪ Orientation/Training ▪ Deployment of MSTs ▪ Monitoring of dashboard	▪ Technical Working Groups (TWGs) 
State	Planning meetings	State EOC/Technical Teams State TFI
	▪ Vaccine, cold chain and logistics ▪ Advocacy, social mobilization and communication ▪ Orientation/Training ▪ MSTs orientation ▪ Compilation of IPD plans ▪ Monitoring of dashboard	▪ Technical Working Groups 

Pre-implementation activities … 2

Level	Major Activities	Responsible
LGA	Planning meeting and development of plans (Schedule of activities, HRA, HROP, training, supervisory, cold chain and logistics… etc)	LGA Technical Team TFI/SMC
	• Vaccine, cold chain and logistics • Advocacy, social mobilization and communication • Orientation/Training • Compilation and Submission of pre-implementation checklist • Review the status of preparedness	▪ LGA Technical Teams 
Ward	• Planning meeting and development of plans (HRA, HROP, • Review of microplans/update • Team selection and training • Cold chain inventory, Vaccines and logistics	Ward technical team – (WFP, CSOs, traditional leaders, team supervisors, village head, partner agencies) 

Roles and responsibilities of National and State level supervisors

PRE-IMPLEMENTATION PHASE

- Conduct advocacy & sensitization to government officials to ensure buy-in & ensure release of counterpart funds
- Participate in training
- Assess cold chain system
- Validate teams' microplan for implementation
- Focus on problematic areas identified during pre-implementation & from previous round performance

INTRA-IMPLEMENTATION PHASE

- Supervise vaccination team & fixed post team using implementation check list & provide on-the-job training
- Ensure maintenance of cold chain for the duration of the campaign (running generators, adequate frozen ice packs)
- Ensure daily monitoring of vaccine utilization by LGA
- Attend evening review meetings to discuss observations & feedback from the field

POST-IMPLEMENTATION PHASE

- Debrief at state level: Discuss best practices, challenges & recommendations

Roles and responsibilities of LGA level supervisors

PRE-IMPLEMENTATION PHASE

- Assist WFP in reviewing & revising micro-plans
- Provide inputs based on analysis of tally sheets/data/problems encountered from previous rounds
- Revise vaccination team distribution, if required
- Ensure appropriate timings for vaccinations team visits
- Plan for supply of vaccine & logistics for vaccination teams

INTRA-IMPLEMENTATION PHASE

- Conduct supervisory visits to HFs: Use implementation check list, provide on-the-job training
- Attend evening review meetings
- Support the teams by (carrying extra materials like tally sheets, summary sheets, vaccines, icepacks, pen markers, chalk & plastic bags & intervene when necessary)

POST-IMPLEMENTATION PHASE

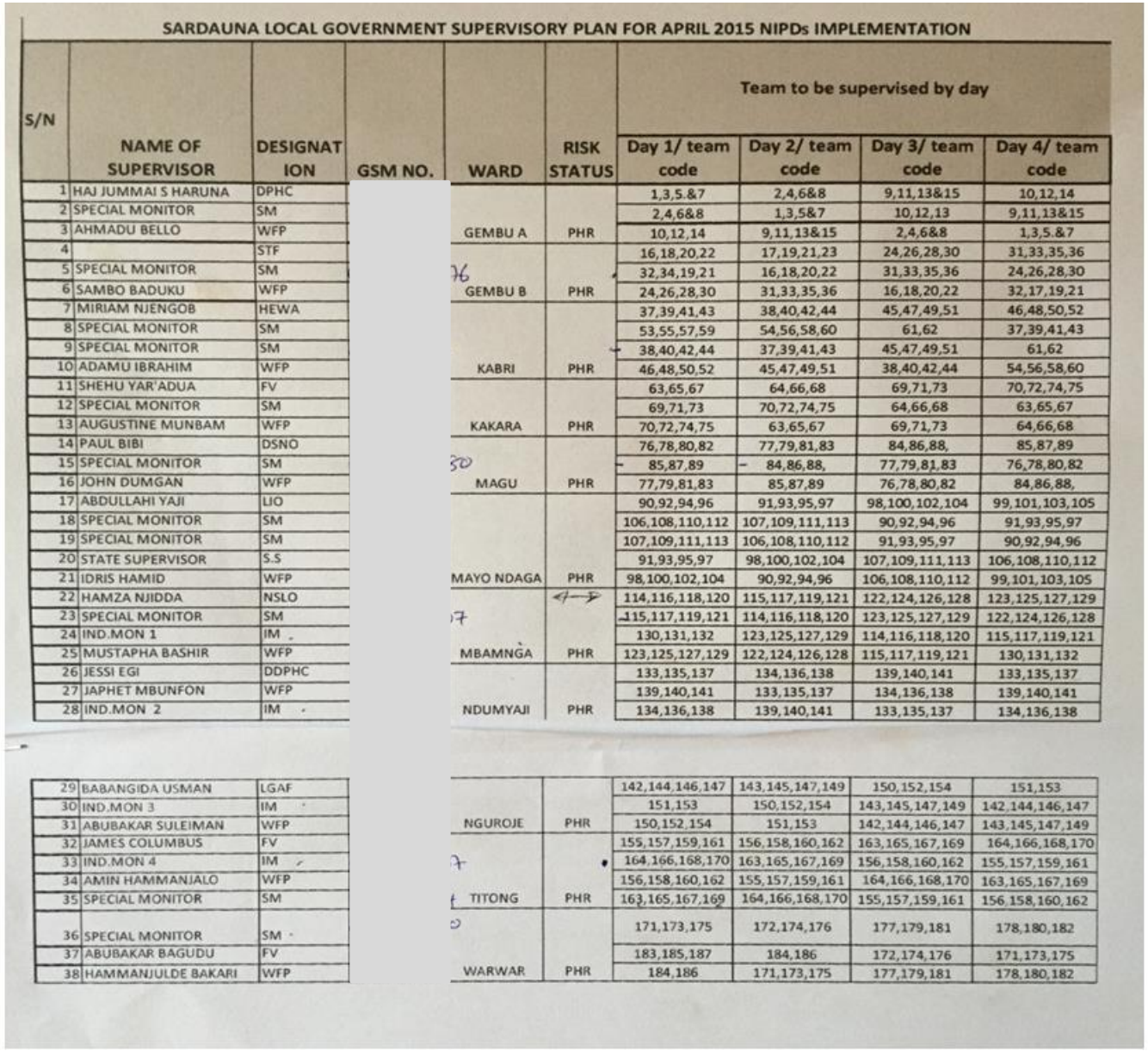
- Debrief at LGA level: Discuss best practices, challenges & recommendations

Implementation supervisory plan – National sample

NEOC APRIL nOPV2 DEPLOYMENT

S/N	Name	Organization	Designation	Phone number	Email	Base	States of Posting	LGA of Posting
1	Abiy Nega	Mcking				FCT	Abia	Isiala Ngwa South
2	Akuneto Reagan Chidi Ndubueze	WHO				Delta	Adamawa	Mayo Belwa
3	Oche James Agada	WHO				Abuja	Bauchi	Darazo
4	Moses Ngbede	UNICEF				FCT	Borno	Konduga
5	Chibianutu Ojimah	WHO				Delta	Jigawa	Gwaram
6	Daniel Dogo	WHO				Kogi	Kaduna	Giwa
7	Dr Ahmed Bello	WHO				Kaduna	Kaduna	Zaria
87	Joshua Hassan	Rotary				FCT	Kaduna	Saminaka
8	Heyllhirra Emmanual	Sultan Foundation				NEOC	Kano	Ungogo
9	Daleen Shamaki	CGPP				FCT	Kano	Ungogo
10	Nnenna Ohiaeri	eHealth Africa				FCT	Kano	Tracking
11	Fatimah Howeidy	eHealth Africa				HQ Kano	Kano	Fagge
12	Pharm Zaitun Ibrahim Saleh	NPHCDA				FCT	Kano	KMC
13	Dr Lucienne Dempouo	WHO				Abuja	Kano	Nasarawa
14	Dr Bassey Enya Bassey	WHO				Kano	Kano	Bagwai
15	Dr Adamu Sule	CDC				Abuja	Kano	Tarauni
16	Dr. Tukur Ismail	SCIDaR				Abuja	Kano	Fagge
17	Dr. Tenmuso Jatau	SCIDaR				Abuja	Kano	Kano Municipal
18	Ahmad Isah Muhammad	UNICEF				FCT	Kano	Tarauni
19	Issa Moussa Usman	UNICEF				FCT	Kano	Bebeji
20	Remi Onilogbo	UNICEF				FCT	Kano	Garun Mallam
21	Gael Maufras Du Chatellier	UNICEF				RO Dakar	Kano	KMC
22	Serekeberehan Seyoum Deres	UNICEF				Kano	Kano	Bagwai
23	Dr Samuel Abbott	AFENET				FCT	Kano	Nasarawa
24	Dr. Salawu Musa S	Mcking				FCT	Kano	Fagge
25	Dr. Richard Banda	Mcking				FCT	Kano	Tarauni
26	Rahman Kelani	Mcking				FCT	Kano	Fagge
27	Halima Muhammad	Chigari Foundation				FCT	Kano	Nasarawa

Implementation supervisory plan – LGA and Ward sample



SARDAUNA LOCAL GOVERNMENT SUPERVISORY PLAN FOR APRIL 2015 NIPDs IMPLEMENTATION

S/N	NAME OF SUPERVISOR	DESIGNATION	GSM NO.	WARD	RISK STATUS	Team to be supervised by day			
						Day 1/ team code	Day 2/ team code	Day 3/ team code	Day 4/ team code
1	HAJ JUMMAI S HARUNA	DPHC				1,3,5.&7	2,4,6&8	9,11,13&15	10,12,14
2	SPECIAL MONITOR	SM				2,4,6&8	1,3,5&7	10,12,13	9,11,13&15
3	AHMADU BELLO	WFP		GEMBU A	PHR	10,12,14	9,11,13&15	2,4,6&8	1,3,5.&7
4		STF				16,18,20,22	17,19,21,23	24,26,28,30	31,33,35,36
5	SPECIAL MONITOR	SM				32,34,19,21	16,18,20,22	31,33,35,36	24,26,28,30
6	SAMBO BADUKU	WFP		GEMBU B	PHR	24,26,28,30	31,33,35,36	16,18,20,22	32,17,19,21
7	MIRIAM NJENGOB	HEWA				37,39,41,43	38,40,42,44	45,47,49,51	46,48,50,52
8	SPECIAL MONITOR	SM				53,55,57,59	54,56,58,60	61,62	37,39,41,43
9	SPECIAL MONITOR	SM				38,40,42,44	37,39,41,43	45,47,49,51	61,62
10	ADAMU IBRAHIM	WFP		KABRI	PHR	46,48,50,52	45,47,49,51	38,40,42,44	54,56,58,60
11	SHEHU YAR'ADUA	FV				63,65,67	64,66,68	69,71,73	70,72,74,75
12	SPECIAL MONITOR	SM				69,71,73	70,72,74,75	64,66,68	63,65,67
13	AUGUSTINE MUNBAM	WFP		KAKARA	PHR	70,72,74,75	63,65,67	69,71,73	64,66,68
14	PAUL BIBI	DSNO				76,78,80,82	77,79,81,83	84,86,88,	85,87,89
15	SPECIAL MONITOR	SM				85,87,89	84,86,88,	77,79,81,83	76,78,80,82
16	JOHN DUMGAN	WFP		MAGU	PHR	77,79,81,83	85,87,89	76,78,80,82	84,86,88,
17	ABDULLAHI YAJI	LIO				90,92,94,96	91,93,95,97	98,100,102,104	99,101,103,105
18	SPECIAL MONITOR	SM				106,108,110,112	107,109,111,113	90,92,94,96	91,93,95,97
19	SPECIAL MONITOR	SM				107,109,111,113	106,108,110,112	91,93,95,97	90,92,94,96
20	STATE SUPERVISOR	S.S				91,93,95,97	98,100,102,104	107,109,111,113	106,108,110,112
21	IDRIS HAMID	WFP		MAYO NDAGA	PHR	98,100,102,104	90,92,94,96	106,108,110,112	99,101,103,105
22	HAMZA NJIDDA	NSLO				114,116,118,120	115,117,119,121	122,124,126,128	123,125,127,129
23	SPECIAL MONITOR	SM				115,117,119,121	114,116,118,120	123,125,127,129	122,124,126,128
24	IND.MON 1	IM				130,131,132	123,125,127,129	114,116,118,120	115,117,119,121
25	MUSTAPHA BASHIR	WFP		MBAMNGA	PHR	123,125,127,129	122,124,126,128	115,117,119,121	130,131,132
26	JESSI EGI	DDPHC				133,135,137	134,136,138	139,140,141	133,135,137
27	JAPHET MBUNFON	WFP				139,140,141	133,135,137	134,136,138	139,140,141
28	IND.MON 2	IM		NDUMYAJI	PHR	134,136,138	139,140,141	133,135,137	134,136,138
29	BABANGIDA USMAN	LGAF				142,144,146,147	143,145,147,149	150,152,154	151,153
30	IND.MON 3	IM				151,153	150,152,154	143,145,147,149	142,144,146,147
31	ABUBAKAR SULEIMAN	WFP		NGUROJE	PHR	150,152,154	151,153	142,144,146,147	143,145,147,149
32	JAMES COLUMBUS	FV				155,157,159,161	156,158,160,162	163,165,167,169	164,166,168,170
33	IND.MON 4	IM				164,166,168,170	163,165,167,169	156,158,160,162	155,157,159,161
34	AMIN HAMMANJALO	WFP				156,158,160,162	155,157,159,161	164,166,168,170	163,165,167,169
35	SPECIAL MONITOR	SM		TITONG	PHR	163,165,167,169	164,166,168,170	155,157,159,161	156,158,160,162
36	SPECIAL MONITOR	SM				171,173,175	172,174,176	177,179,181	178,180,182
37	ABUBAKAR BAGUDU	FV				183,185,187	184,186	172,174,176	171,173,175
38	HAMMANJULDE BAKARI	WFP		WARWAR	PHR	184,186	171,173,175	177,179,181	178,180,182

NAMES OF WFP AND NUMBERS

S/N	NAME	RANK	WARD	PHONE NUM.	PHONE NUM.
1.	AHMADU BELLO	CHEW WFP	GEMBU A		
2.	SAMBO BADUGU	CHEW WFP	GEMBU B		
3.	ADAMU IBRAHIM	DCH WFP	KABRI		
4.	AUGUSTINE LUCAS	CHEW WFP	KAKARA		
5.	JOHN DOMGANG	DCH WFP	MAGU		
6.	IDRIS HAMIDU	DCH WFP	MAYO NDAGA		
7.	MUSTAPHA B BASHIRU	DCH WFP	MBAMNGA		
8.	ADAMU ABDULLAHI	CHEW WFP	NDUMYAJI		
9.	JOSEPH ISAIAH	CHEW WFP	NGUROJE		
10.	SULEIMAN ABUBAKAR	CHEW WFP	TITONG		
11.	HAMM. BAKARI	CHEW WFP	WARWAR		
12.					

BY AUGUSTINE N. JAURO CCO.

What to look out for when supervising vaccination teams

- Availability of DIP
- Teams' operation
  - Team composition
  - Vaccine administration (2 drops)
  - Proper finger-marking (left little finger)
  - Proper house-marking
  - VVM status of antigen in use
  - Documentation in appropriate data tools (tally sheet, e-tally, enumeration list/ComCare)
  - Accountability for supplies and commodities

Key Elements of Team Performance

- Correct team movement
- Correct house marking
- Correct finger marking of children
- Good communication skills
- Right recording/tallying
- Ensure maintenance of cold chain system
- Social mobilization

Supervisory tools and additional supervisory layer

Category of Supervisor	Checklist	Location	Campaign Phase	States
MST	(A management level checklist will be shared)	TBP	Pre & Intra	All states
	IPDs_PreImplementation_Checklist	WHO Partner's Server	Pre	
	IPDs_Training Checklist_v1	WHO Partner's Server	Pre	
	Polio ACSM Monitoring Tool	WHO Partner's Server	Pre, Intra & Post	
	MST_DOPV_Supervisory_Checklist	WHO Partner's Server	Intra	
	MST_IPDs_Concurrent_Monitor_Operational_Component	WHO Partner's Server	Intra	
Senior Supervisors Supervisors	IPDs_PreImplementation_Checklist	WHO Partner's Server	Pre	All states
	IPDs_Training Checklist_v1	WHO Partner's Server	Pre	
	Polio ACSM Monitoring Tool	WHO Partner's Server	Pre, Intra & Post	
	MST_DOPV_Supervisory_Checklist	WHO Partner's Server	Intra	
	MST_IPDs_Concurrent_Monitor_Operational_Component	WHO Partner's Server	Intra	
ACASUS Independent Evaluators	Accountability Checklist	ACASUS	Pre, Intra & Post	Selected states
Independent Monitors	Inside-Household Independent Montoring Checklist	WHO Server	Intra	All states
	Outside-Household Independent Montoring Checklist	WHO Server	Post	
Independent Cluster Supervisors	Independent Cluster Checklist	WHO Partner's Server	Intra	Kano, Borno, Yobe, Jigawa, Kebbi, Kaduna, Zamfara
Independent Team Supervisors		WHO Partner's Server	Intra	Sokoto & Katsina

Providing Feedback after Supportive Supervision

1. Immediate feedback on the field to WFP, LIO, SIO, etc. for immediate action

2. Evening review meetings
   - Ward level
   - LGA level
   - State level
   - National

Evening review meetings schedule

Level	Ward	LGA	State	National
Time	1 - 2 pm	3 - 4 pm	4:30 - 6 pm	8:30 - 10:30pm
Participants	1. WFPs 2. Team supervisors 3.Independent team supervisors 4.Cluster supervisors 5. All other higher-level supervisors who supervised in the Ward 6. VAOs	1. LGA team 2. WFPs 3. State supervisors 4. National supervisors 5. Traditional institution 6. Independent monitors	1. State team 2. Implementing partner leads at the state 3. National supervisors	1. NEOC members 2. State teams led by the ES/ED/Chairman SPHCDA 3. Implementing partner leads at the national
Discussion points	1. Vaccine accountability 2. Challenges 3. Resolutions	1. Children vaccinated 2. Vaccine accountability 3. Challenges 4. Resolutions	1. Review of intra-campaign dashboard 2. Challenges 3. Resolutions	1. Review of state presentations 2. Challenges 3. Resolutions

Deliverables for Supervisors

- **Submit data generated from monitoring and supervision for prompt action (call-in, In-process Monitoring, ODK, Vaccinator Tracking System, Mock LQAs)**
- **Submit ODK to NEOC, showing monitoring of at least 3 teams per day**
- **Submit a comprehensive report of the program to NEOC using the approved template**
- Ensure challenges encountered have been resolved or escalated to appropriate quarters & documented/shared

Conclusion

- Supervision ensures that planned activities are carried out without hitches
- Supervisors at the various level of supervision have crucial roles to play to ensure quality outcome
- Availability of the right supervisory tool is critical to ensure quality supervision and feedback
- With quality supervision the goal of closing the immunity gaps can be achieved

Thank you

Cross-Border & Vaccination in Special Places

WHO APHO/SIO

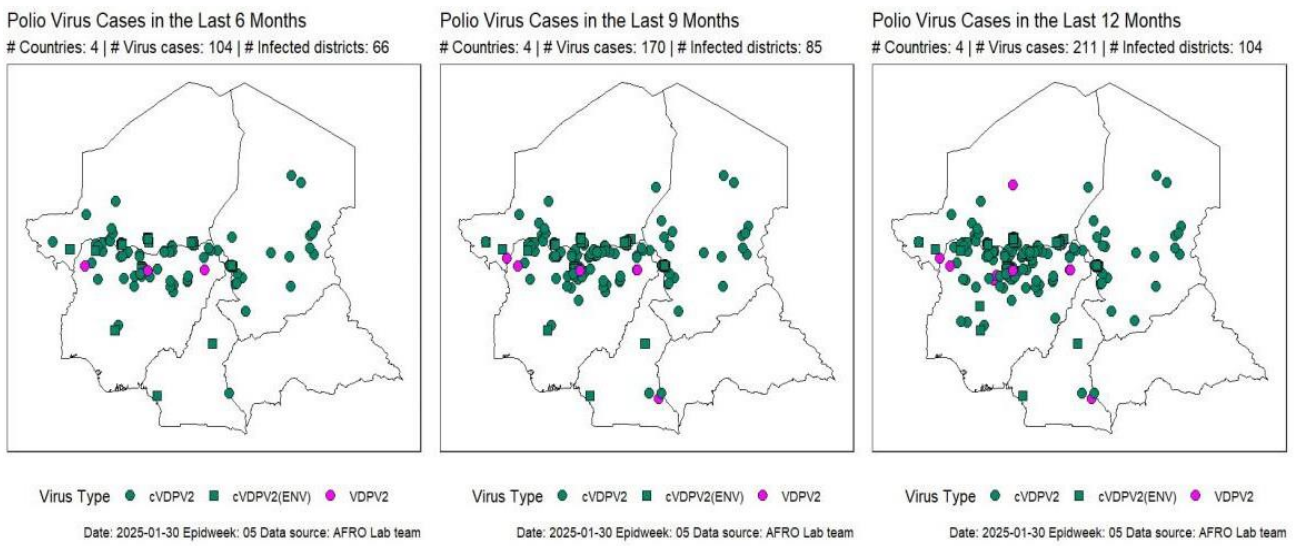
Outline

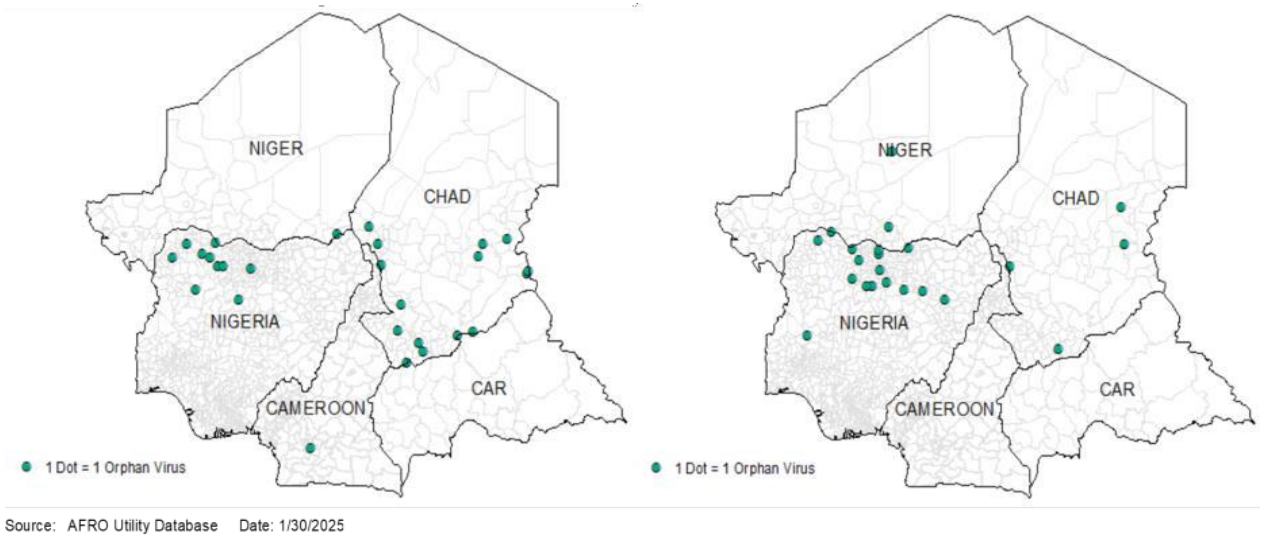
1. Background
2. International Border Synchronization
3. Vaccination in Special Places
4. Summary

Source: Team analysis

Background

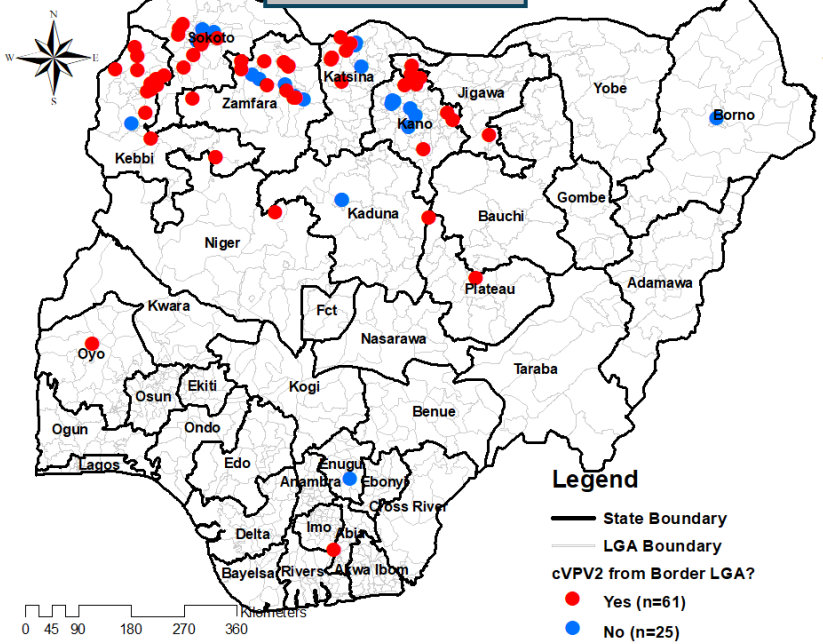
- Nigeria has international border with Niger, Chad, Cameroon and Benin Republic
- There are reported cases of cross-border transmission of cPV2s in the last 2 years including orphan cVPV2s
- Polio NIDs will be conducted in the first half of 2025 in LCBC as follows



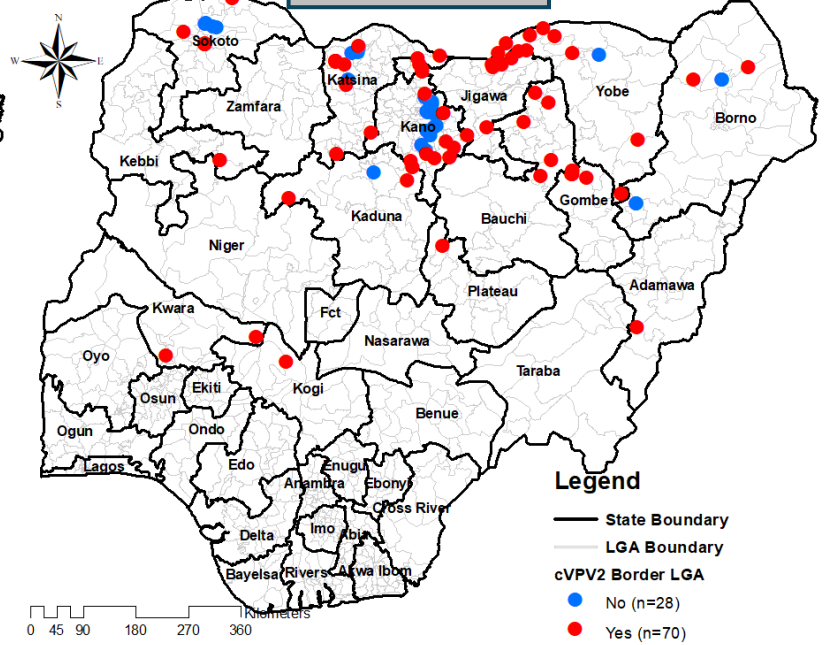


Distribution of cVPV2 Cases by bordering/non-Bordering LGAs

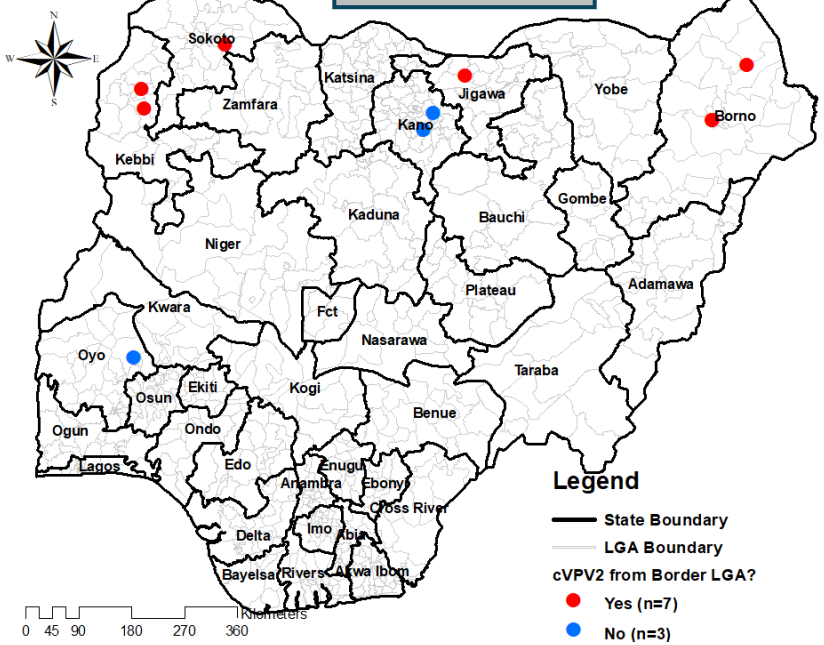
2023



2024



2025

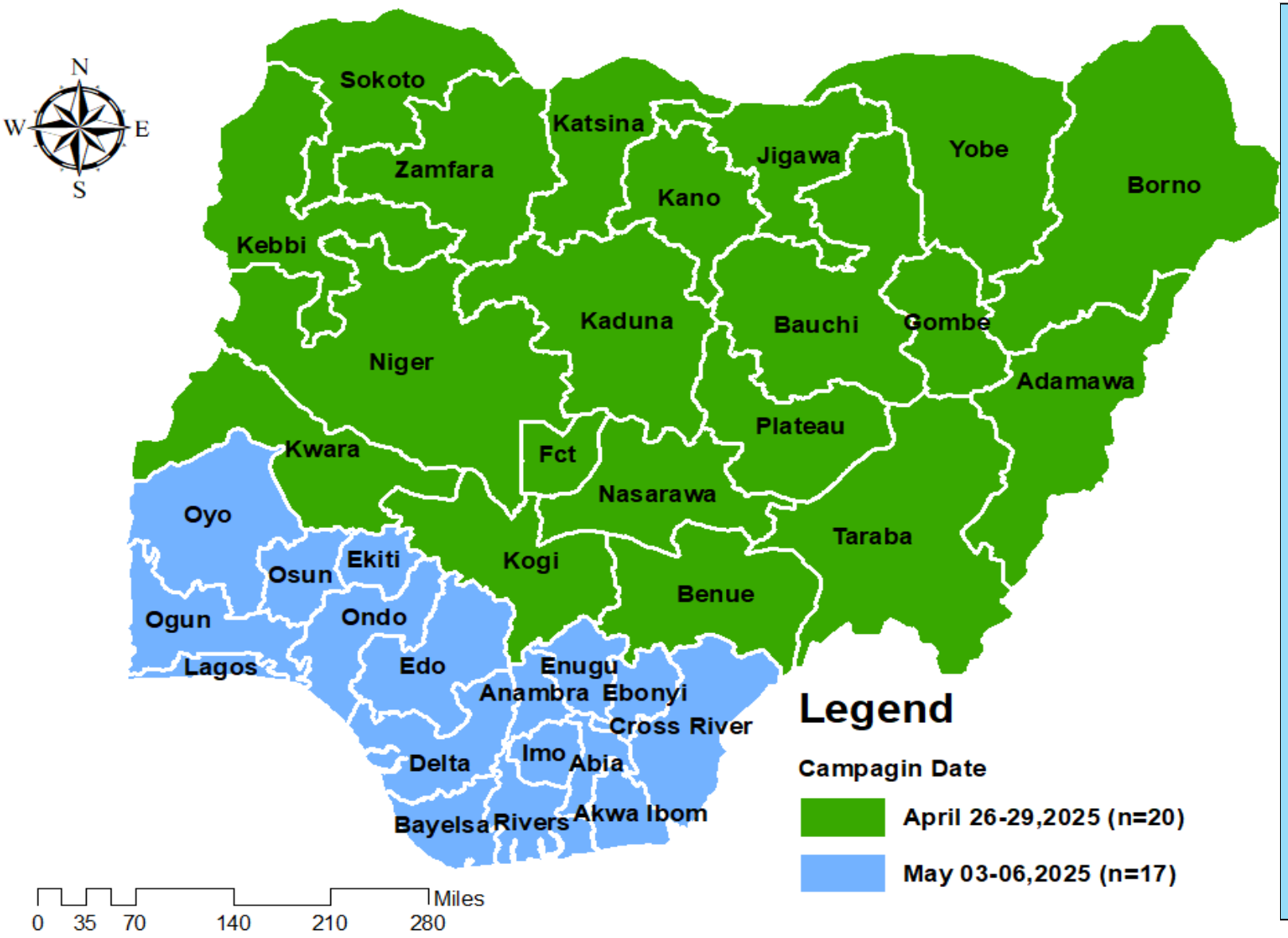


Province	Border LGA			%
	No	Yes	Total	
ABIA	0	1	1	100%
BORNO	1	0	1	0%
Enugu	1	0	1	0%
Jigawa	0	2	2	100%
Kaduna	2	1	3	33%
Kano	6	7	13	54%
KATSINA	4	7	11	64%
KEBBI	1	14	15	93%
Niger	0	1	1	100%
OYO	0	1	1	100%
PLATEAU	0	1	1	100%
Sokoto	5	13	18	72%
Zamfara	5	13	18	72%
National	**25**	**61**	**86**	**71%**

Province	Border LGA			%
	No	Yes	Total	
Adamawa	0	1	1	100%
Bauchi	0	5	5	100%
Borno	4	2	6	33%
Gombe	0	5	5	100%
Jigawa	0	12	12	100%
Kaduna	1	3	4	75%
Kano	14	10	24	42%
Katsina	4	12	16	75%
Kebbi	0	2	2	100%
Kogi	0	1	1	100%
Kwara	0	2	2	100%
Plateau	0	1	1	100%
Sokoto	4	6	10	60%
Yobe	1	8	9	89%
National	**28**	**70**	**98**	**71%**

Province	Border LGA			%
	No	Yes	Total	
BORNO	0	3	3	100%
JIGAWA	0	1	1	100%
KANO	2	0	2	0%
KEBBI	0	2	2	100%
OYO	1	0	1	0%
SOKOTO	0	1	1	100%
National	**3**	**7**	**10**	**70%**

Scope of International border synchronization, April 2025



For April round synchronization dates

- CAR and Cameroon: 24th to 27th April 2025.
- Niger and Chad: 25th to 28th April 2025.
- **Nigeria: 26th to 29th April 2025.**

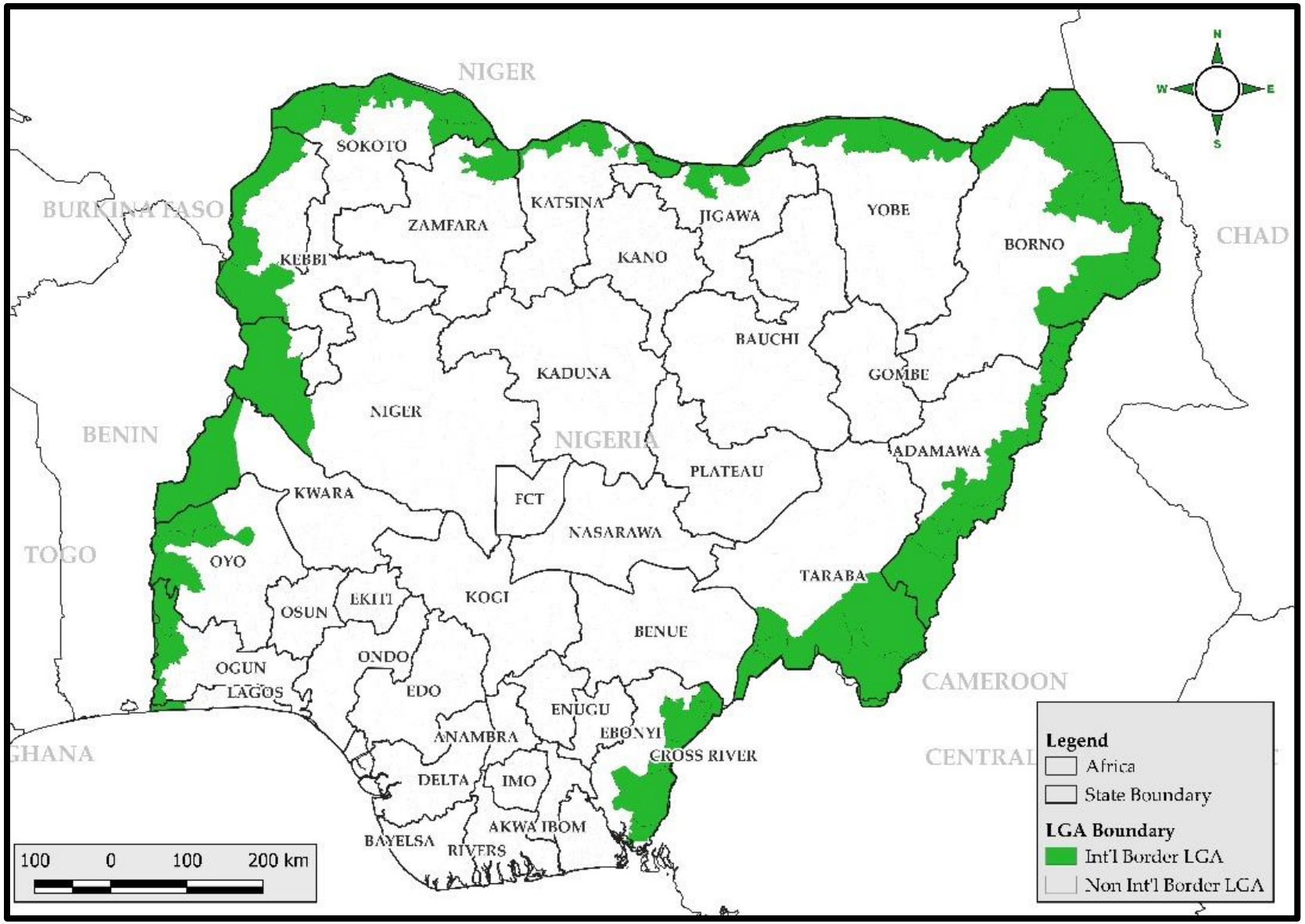
For May round synchronization dates

- CAR and Cameroon 29th May to 01st June 2025.
- Niger and Chad: 30th May to 02nd June 2025.
- **Nigeria: 31st May to 03rd June 2025.**

International Border Synchronization Campaign, April 2025

State	Country	Date of implementation (April 202)	Comment
Kebbi, Niger, Kwara, Oyo, Ogun, Lagos	Benin Rep	Not implementing	States & LGAs to explore vaccinating across border during Border synchronization meeting
Sokoto, Zamfara, Katsina, Jigawa, Yobe, Borno	Niger Rep	**Niger Re:** 25th to 28th **Nigeria:** 26th to 29th	Agree with Niger Rep on a date, b/w **26th and 29th**
Borno	Chad Rep	**Chad Rep:** 25th to 28th April **Nigeria:** 26th-29th	Nigeria's Island settlements on the Lake Chad are inaccessible for synchronization
Borno, Adamawa, Taraba, Benue, Cross Rivers, Akwa Ibom	Cameroon Rep	**Cameroon Rep:** 24th to 27th **Nigeria:** 26th to 29th	Agree with Cameroon Rep on a date b/w **26th and 27th April 2025**

International border synchronization Plan development, April 2025



- Border synchronization meetings (International, Inter State, Inter LGA, Inter ward border) has been scheduled for 10-13 April 2025
- State Team(IM/SEOC), DPHC & WFP will be responsible for Border synchronization Plan development at each level
- This plan should be harmonized/integrated into the LGA & ward micro plan and the international border team DIP

Border Synchronization activities (1/2)

- International border settlements list Must be validated and updated during Ward validation meeting
- Rationalized DIP to ensure appropriate allocation of vaccination teams, supervisors and transport logistics to border areas
- Plan for adequate vaccines and data tools
- Utilize community volunteers and organization during micro planning and DIP development
- Plan for both settlement and border crossing points vaccination and deploy teams as appropriate
- Include international/busy weekly markets happening withing the campaign dates
- Strive to validate the border Micro plan

Border Synchronization activities (2/2)

- ACSM Plans to ensure cross-border ACSM activities are planned for
- Activate non-compliance resolution committees
- Create awareness on campaign using appropriate languages
- Use appropriate, locally adopted IEC materials
- Engage traditional, religious and community leaders and influential people
- Engage migrant population leaders in planning

- Conduct border synchronization meetings
  - Synchronization dates & venue
  - Discuss best strategy e.g. Back-to-Back
- Border Synchronization Plan
  - Supervision
  - Vaccination-Settlements and crossing point
- Data Capture and monitoring implementation

Inter state, LGA, ward, settlement and Team Border

- Usually are the areas with limited supervision, poor team performance, missed settlements, missed households and active transmissions of CVPV2s
- Should be plan well and be monitored
- Adequate supervisors should be deployed and tracked
- Border plans and synchronized vaccination must be conducted and reported

Vaccination in Special Places

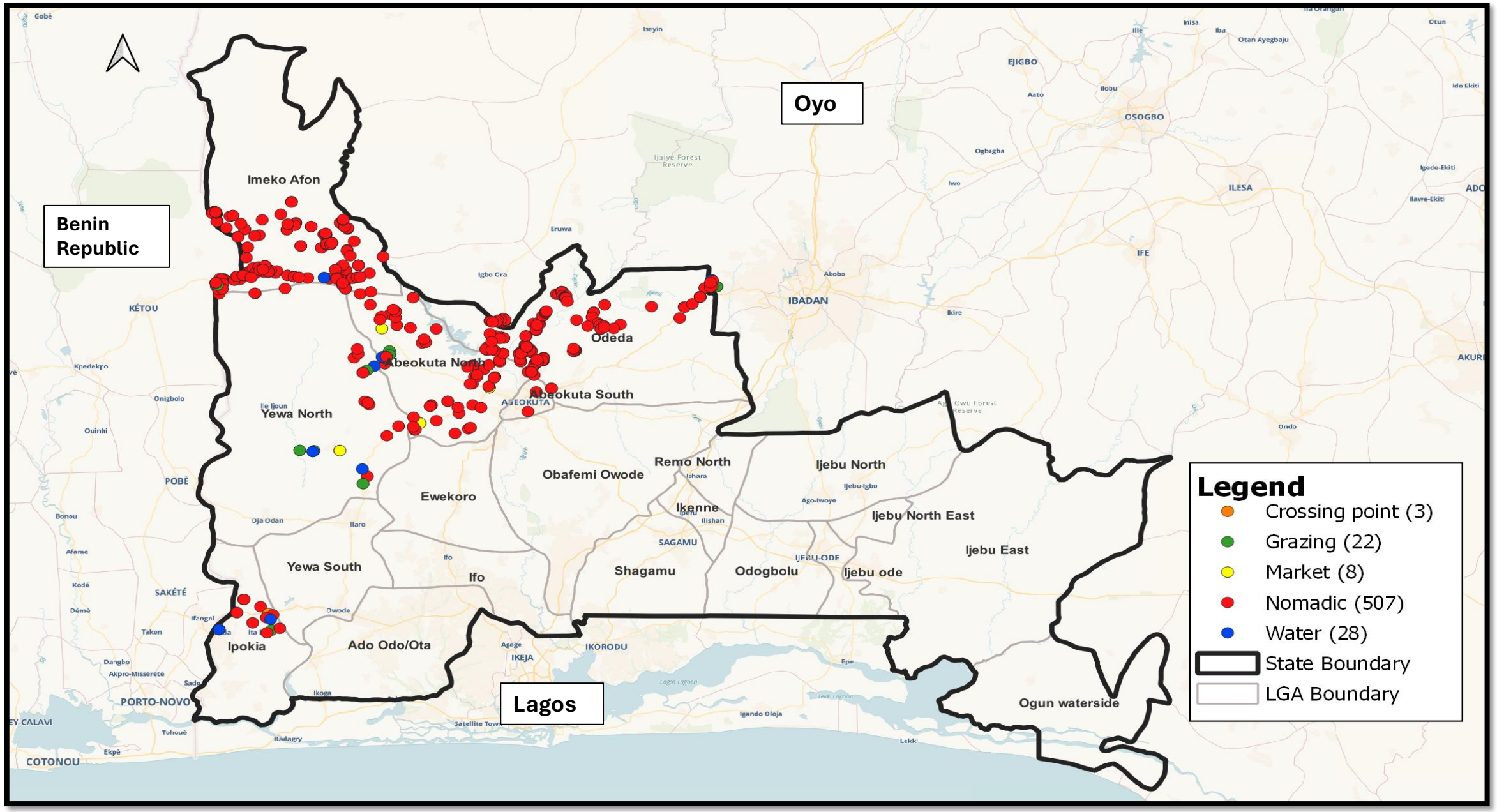
Planning for Vaccination in Special places

- The state team ensure micro plans are developed by each LGAs to capture Hard to reach, scattered, migrant population, border settlements and security compromised areas
- LGA teams are to guide and supervise the respective WFPs in the process of walkthrough
- WFPs are responsible for ward level walkthrough exercise, supervise and guide TS while conducting walkthrough
- The team must be familiar with the terrain, while the community leader/guide must come from the community
- Team should use a checklist to ensure they carry along all their data tools
- Areas with heightened insecurity should be avoided by regular teams, however other community resources persons could be used instead
- LGA should inform/engaged security agencies while planning

Micro plans and DIPS Must clearly indicate security categorization of each settlement

SN	LGA NAME	WARD NAME	SETTLEMENT_NAME	Accessible	Partially accessible	Inaccessible
1	Abadam	Arge	ALIJILLAMARI	Accessible		
2	Abadam	Arge	ANGUWAN KURNA		Partially accessible	
3	Abadam	Arge	AREGE		Partially accessible	
4	Abadam	Arge	BAKARE			Inaccessible
5	Abadam	Arge	BAKIN KASUWA	Accessible		
6	Abadam	Arge	BARAM KINDILLA			Inaccessible
7	Abadam	Arge	BARTA'A		Partially accessible	
8	Abadam	Arge	BISKU		Partially accessible	
9	Abadam	Arge	BULABULIN	Accessible		
10	Abadam	Arge	BULAMARI		Partially accessible	

Distribution of Nomadic Service points, Ogun State 2022



Nomadic and Border vaccination during SIA

- Micro planning
- Team selection and deployment
- Social Mobilization: Advocacy to nomadic leaders and involvement during planning
- Supervision and monitoring
- Team and supervisors Logistics
- Strengthening RI during SIA
- AFP and VPDs surveillance during SIA
- Nomadic data Management
- vaccine accountability

Thank you

Implementation of Accountability

SIO

What will the program be measured on?

Key performance indicators

We will measure performance at all phases of the campaign leveraging data collected independently

	Pre - campaign *Assessing campaign preparedness (processes and quality)*	**Intra - Campaign** *Driving accountability actions in the areas that most impact effective vaccination delivery*
What will be collected?	**Assessing processes:** • **Funding:** *Were funds disbursed and received timely by the state, LGA and vaccinators?* • **Logistics (vaccines & pluses):** *Were vaccines and pluses distributed timely to the states and LGAs?* • **Team selection:** *Were teams selected as per the selection protocol?* **Assessing the quality of critical campaign dependencies:** • **Microplan readiness:** *Were microplan developed in the best quality (using MLoS, IEV etc)?* • **Training:** *Were quality trainings conducted at ward level ?* • **ACSM:** *Were all ACSM activities executed at a high quality?*	**Vaccine mismanagement:** *Did teams waste vaccines on the field? (e.g. pouring vaccines away or other mismanagement activities)* **Fake-finger marking:** *Were teams involved in fake finger making practices?* **Data falsification:** *Were teams involved in over-tallying/data fraud?* **Team performance:** *Were teams able to translate basic knowledge acquired on the field?*
Who will collect the data?	• **Independent evaluators deployed by Acasus**	• **NEOC independent supervisors**
When will this data be collected?	• Starting 3 weeks before campaign	• All through the campaign - 6 days

Source: Team analysis

Intra campaign Focus Areas

We will also track and manage PSEA related Incidents from the Ethics Hotline

Call placed to ***[0800-0000-362]*** *from the field*

Incident Received

National hotline shares state incident with AFEC

Investigation & Action

AFEC investigates the incident and recommend/takes action against involved parties (if required)

Report

Document the incident and the action taken/not taken in the monthly/post-campaign report

Share incidents in the monthly/post-campaign report with State and National EOC

Source: Team analysis

Where will we do this?

Scope, priority LGAs and wards

We will deploy **120 independent evaluators** in the **2025 April round**

LINK to the prioritized wards

Scope

6
States

60
LGAs

360
wards

States	# LGAs (⅓)	LGA Names[1]	Total # Wards
Kano	16	Ajingi, Bunkure, Dala, Dambatta, Dawakin Kudu, Fagge, Gezawa, Kano Municipal, Karaye, Kumbotso, Nasarawa, Sumaila, Takia, Tarauni, Ungogo, and Warawa	96
Jigawa	10	Birniwa, Dutse, Garki, Hadejia, Kaugama, Kazaure, Kiyawa, Maigatari, Sule, Tankarkar and Yankwashi	60
Katsina	12	Baure, Bindawa,Dutsi, Dutsin Ma, Ingawa, Kankia, Katsina, Mai'Adua, Mani, Mashi, Musawa and Zango	72
Kebbi	8	Aleiro, Argungu, Birnin Kebbi, Bunza, Gwandu, Kalgo, Suru and Yauri	48
Sokoto	9	Binji, Bodinga, Gada, Gwadabawa, Kware, Sokoto North, Tangaza, Tureta and Wamakko	54
Zamfara	5	Bakura, Bungudu, Gummi, Gusau, Talata Mafara	30

- In each LGA we will have 2 data collectors and each data collector responsible for visiting 3 wards, We selected polio high risk wards across each LGA
- We will also identify 6 state supervisors who will help our team with state coordination
- The data evaluators and supervisors **will work the State, LGA and ward to fix issues especially those related to quality**
- **The team will also do phone call validation to additional selected LGAs/wards to validate preparedness pre-campaign**
- **Intra campaign phase, we will select one LGA representative from the pool of evaluators to serve as the Accountability officer during the LGA review meetings**

1. A set of LGAs selected based on poor performance in 2024 AF OBR 3, 4 and 5

Source: Team analysis

What are the agreed ramifications?

Rewards and Sanctions

Accountability measures

Theme	Proposed measures	Decision makers
Partners	• **Immediate written warning or query:** Issue a formal warning or query to the Country Partner Lead if performance issues arise. • **Reassignment of partner functions:** Reallocate or adjust the partner's role in the next campaign cycle based on performance and compliance. • **Flag performance issue with donor:** Submit a comprehensive report to the donor (GPEI) highlighting performance issues and recommending necessary actions.	ED-NPHCDA
Government	• **Verbal warning:** Provide immediate feedback and warnings to underperforming parties during campaign implementation	IM NEOC/SEOC
	• **Written warning/query:** Issue formal queries to responsible entities if performance issues persist after initial warning especially post campaign	ES SPHCDA/HCH
	• **Reassignment or removal of personnel:** Based on performance assessments, reassign or disengage underperforming staff at appropriate levels **both during and after the campaign.**	ES SPHCDA/HCH Dir. PHC/LGA chairmen
	• **Dropping of team:** Based on issues reported around fake finger marking and data falsification, drop and blacklist teams involved **during the campaign**	ES SPHCDA/HCH LGA chairmen

Sanctions for vaccination team

Ward level training

BAD PRACTICES	ACCOUNTABILITY MEASURES
VACCINATION TEAMS involved in:	
FAKE FINGER MARKING (1)	**DROP IMMEDIATELY & BLACKLIST TEAM FROM SUBSEQUENT CAMPAIGNS**
DATA FALSIFICATION/ OVER-TALLYING (2)	
VACCINE MISUSE/ POURING VACCINE (3)	
POOR PERFORMANCE: **NON-COMPLIANCE CONCEALMENT, WRONG HOUSE MARKING, LATE TAKE-OFF, POOR CCE HANDLING, POOR VVM KNOWLEDGE, SKIPPING HOUSEHOLD** (4)	**ISSUE VERBAL/WRITTEN WARNING TO TEAM**
PERSISTENT POOR PERFORMANCE AFTER WARNING: **NON-COMPLIANCE CONCEALMENT, WRONG HOUSE MARKING, LATE TAKE-OFF, POOR CCE HANDLING, POOR VVM KNOWLEDGE, SKIPPING HOUSEHOLD** (5)	**DROP IMMEDIATELY & BLACKLIST TEAM FROM SUBSEQUENT CAMPAIGNS**

Source: Team analysis

Thank you

Ethics & Integrity: Prevent, Detect & Respond to Misconduct

Okwu Onyinyechi

Prevent, Detect and Respond to Misconduct: Fraud, Corruption, Sexual Exploitation, Abuse & Harassment

1. The core values of the NEOC and its partners are deeply rooted in dignity, justice, inclusiveness and accountability
2. WHO is committed to providing a work environment that respects the inherent dignity of all persons. Resources are to be used, and responsibilities undertaken in ways that are mutually transparent and answerable to all stakeholders.
3. Reports of unethical behaviour or misconduct will be addressed promptly, respectfully, and effectively in accordance with the applicable regulatory framework and the procedures
4. Every person, team member has the right to be treated with dignity and respect, and a corresponding responsibility to actively promote such an environment and to behave in accordance with the NEOC as well as WHO's principles
5. Know the standards of conduct or ethical behaviour expected from you and be aware of fraud, corruption & sexual misconduct risks when delivering the joint NEOC and WHO's mission

Fraud and Corruption: *Examples of conduct constituting (but not limited to) fraudulent or corrupt practices*

- **Facilitation payment** – This form of corruption is also called 'grease' payment. It is made to speed up a 'routine action' to which the payer is entitled. It does not aim at changing the outcome.
- **Kickback** – Something of value that is given as a 'compensation for services rendered' (i.e. a commission). This form of negotiated bribery is pre-agreed between the parties (collusion)
- **Bribery** – is the offering, giving, receiving or requesting of anything of value to influence the actions of an individual holding a legal duty. Both the offeror and the recipient are engaging in unethical behaviour.
- **Cronyism** – is the practice of partiality in awarding jobs and other advantages to friends or trusted colleagues.
- **Conflict of interest** – occurs when private interests, may it be financial, personal or other non-WHO interest or commitment interfere with ability to act impartially and fulfil functions.
- **Nepotism** – practice among those with power or influence of favouring relatives or friends, especially by giving them jobs
- **Illegal gratuity** – Something of value that is given by one party, who benefited from a decision, to another who made the decision. It is not given for the purpose of influencing an act but rather because of the act.
- **Forgery** or alteration of any financial or official document (e.g. cheques, agreements, financial reports and audits)

The consequences of "not acting" are wide and far reaching:
WE ARE ALL AFFECTED WHEN FRAUD OCCURS

- **For beneficiaries or people, we serve, it means** lives not changed or not saved.
- **For WHO and its partners, this means** decreased productivity, low staff morale, investment of time and money into investigations and remediation, reputational damage and loss of donor confidence.
- **For the team,** increased scrutiny, decreased trust and the need to clean up after a mess.
- **For perpetrators,** termination of contract, jail terms, pressure of concealing fraud & corruption.

Sexual misconduct including Sexual Exploitation, Abuse & Harassment (SEAH)

is inappropriate sexual conduct perpetrated by aid or health workers workers against community members who are receiving assistance and against those we work with.

It includes:

- Any sexual activity with children
- Offering money, gifts, or a job in exchange for sex
- Withholding due health services or blackmailing for sex
- Attempted or actual sexual assault

- Raping or attempted rape
- Hiring prostitutes
- Threats of sexual exploitation
- Unwanted kissing, touching, grabbing, or rubbing
- Threats of an unwanted sexual act

Sexual exploitation and abuse impacts the mental, physical and emotional welfare of Victim/survivors

SM can happen anywhere and at any time and it is EVERYONE's responsibility

Sexual misconduct (SM) is an abuse of the trust and confidence placed in WHO, our staff and collaborators

It affects the safety of our operational environments, and the reputation of the Organization!

For perpetrators, termination of future engagement, Possible criminal proceedings

As Healthcare workers, we must acknowledge that we hold **power** over people in locations we serve in, and that power can be easily misused to do harm resulting in sexual exploitation, sexual abuse and sexual harassment

Reporting Misconduct

- The NEOC is dedicated to record and handle cases of ethical violations, giving opportunity to all Polio workforce to report cases confidentially and (anonymously if you prefer) without fear
- To report in good faith, any violation of ethics and integrity related to the Polio programme, please call toll-free 0800-000-362
- Your voice is essential in maintaining a transparent and accountable environment and programme
- We encourage everyone to speak up if you witness any practices that do not align with our shared programme values

Responsibilities of the Polio workforce:

- Set a good example in line with the Code of Ethics and Professional Conduct
- Do not engage in, or encourage others to engage in unethical behaviour
- Promote a respectful work environment that prevents misconduct
- As soon as unethical conduct is witnessed or concern about such misconduct is heard, report it to 0800-000-362
- Do not: Spread rumours on fraudulent or corrupt behaviour.
- Do not: Cover up or encourage others to cover up fraud or corruption.

Prevention of unethical conduct including fraud, corruption, sexual exploitation and abuse starts with you

Let's protect health outcomes by detecting and reporting unethical conduct

Respond to fraud, corruption, sexual exploitation and abuse: doing nothing is not an option

Digital Payment in Nigeria

WHO PA/WHO SO

Digital Payments in Nigeria

World Health Organization

Integrating Commcare enrolment in the National Schedule of Activities

11 April 2025

Discussion Outline

World Health Organization
REGIONAL OFFICE FOR Africa

01 Objectives

02 Commcare implementation history in the Southern Zones

03 Process: Trainings

04 Process: Enrolment and Payment Activity Cards

05 Process: Tracking

06 Processing Payments

Objectives

Integrating Commcare enrolment in the National Schedule of Activities

1. Streamline the payment process
2. Delivery as One (DaO) – a National program
3. Synergy – pooling resources (human and material) for an efficient process

Commcare implementation history in the South-South, South-East and South-West

Zone	State	Campaign History
South-East	Abia	Measles, Polio multiple
South-East	**Anambra**	**Not implemented**
South-East	Ebonyi	Measles 2023
South-East	**Enugu**	**Not implemented**
South-East	Imo	Measles
South	**Akwa-Ibom**	**Not implemented**
South	Bayelsa	Measles 2023
South	**Cross-River**	**Not implemented**
South	**Delta**	**Not implemented**
South	**Edo**	**Not implemented**
South	**Rivers**	**Not implemented**
South-West	Ekiti	Polio 2023
South-West	Lagos	Polio, multiple campaigns
South-West	Osun	Polio 2023
South-West	Ondo	Polio 2023
South-West	Ogun	Polio 2023
South-West	Oyo	Polio, multiple campaigns

- The majority of States that have not implemented Commcare are in the South-South and South-East
- Although some States in these zones have implemented Commcare previously, only Lagos, Oyo and Abia have implemented recently
- State level training has been conducted in all States in these zones
- Therefore, WCO will support the 7 frontier States that have not implemented Commcare:
    - WCO member to visit each State
    - Team to support State-level and LGA-Level trainings
    - Team to support Enrolment and tracking
    - Dedicated DDM Personnel per State for all technical troubleshooting

Process: Commcare app training

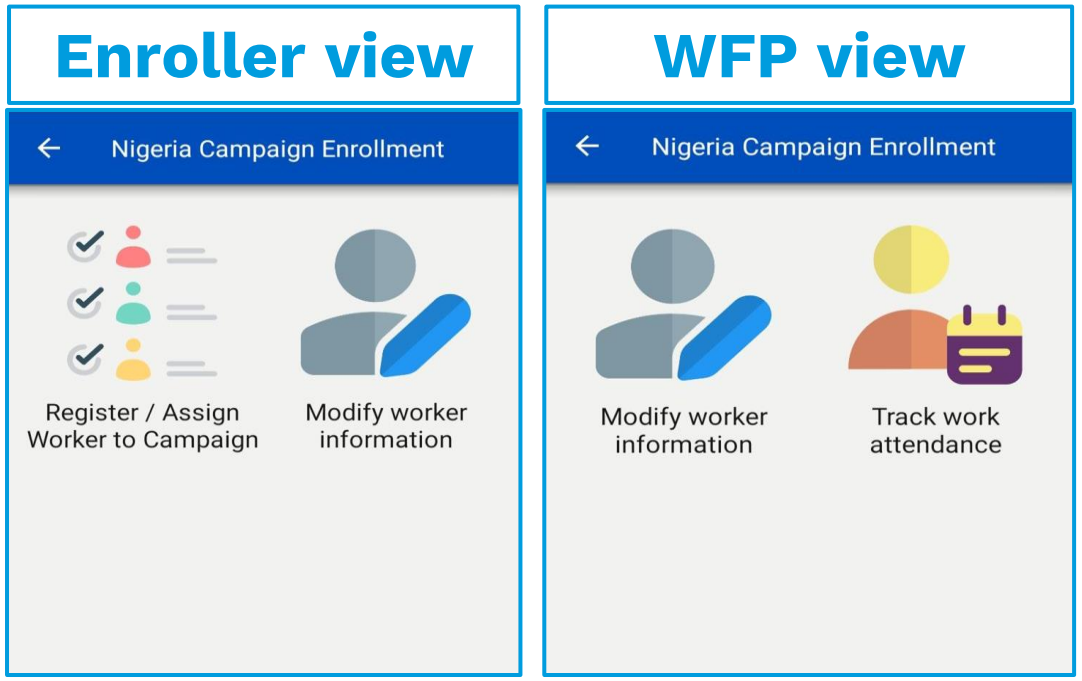
Category	State level Training	LGA level training
Participants	CC/STF, LGAF, LIO/CCO, LGA Data Clerk	Field volunteers/Independent Enrollers, Ward Focal Persons
Trainer	**State PA and State Data Clerk** Trained WHO State office team can support	**LGAF/LIO/CCO/Data Clerk**
Training objective	TOT on the use of Commcare	App users who will enrol or track workers

Synergy:

- All Commcare trainings will now be integrated into the National Training Program
- In the state level training, only the Data Clerk will be a new addition to the training participants

Process: Enrolment and Payment Activity Cards

- **Enrolment starts after team selection**
- **Field volunteers will enrol teams according to set targets**
  - Where there are no field volunteers, Independent Enrollers will be engaged
  - Dedicated DDM team and State PAs will provide technical assistance and troubleshooting
- **Payment Activity Cards**
  - Must be distributed immediately after team selection is finalised
  - Importance of Payment Activity Cards in the process: for data capture in the app, accountability, Team member Identification & Validation



Synergy:

- All Commcare trainings will now be integrated into the National Training Program
- Payment Activity Cards will be given to the worker prior to campaign start – team members must bring passport photo to the training

Process: Tracking

- **Ward Focal person is responsible for tracking all team members including themselves**
- **Tracking starts on the last day of the campaign (day 4) or mop up day 1 (day 5)**
- **Tracking is completed by mop up day 2 (day 6)**

Processing Payments

- **Payment list is extracted, cleaned and finalised by the State PA, with support from the SIA FP/LGA teams**
- **Payment list is sent to the WHO Country Office (WCO) for verification and checks**
- **State endorses verified payment list and sends the signed summary sheet to WCO**
- **WCO processes approvals for payment via Bank payment platform**
- **The teams receive their payments within a day or a few days in their accounts**

IMPORTANT:

- All team members with any financial service provider (e.g. Banks, MFIs [e.g. Opay, Moniepoint etc] and Mobile Money) can be enrolled on Commcare

Post-test

ALL

Post-Test NTOT

https://tinyurl.com/ntotposttest2025

For Support:
WhatsApp – 07087408077

Next Steps

DDCI

Key Next Steps/Call to Action

1. LGA Level Cascade of Implementation Training
2. Selection of Team Members for Screening and Training at the Ward Level
3. Implementation of Mini Microplan Walkthrough in 23 wards, 118 Teams
4. State Level and LGA Level CommCare Training
5. State (LGA) & LGA (ward) HRA/HROP template to be shared by CoB Thursday
6. Populate the dashboard (state & LGA) & submit as much as possible (SIO, WHO SC, NPHCDA SC)
7. National Supervisors will be deployed ten (10) days to the campaign