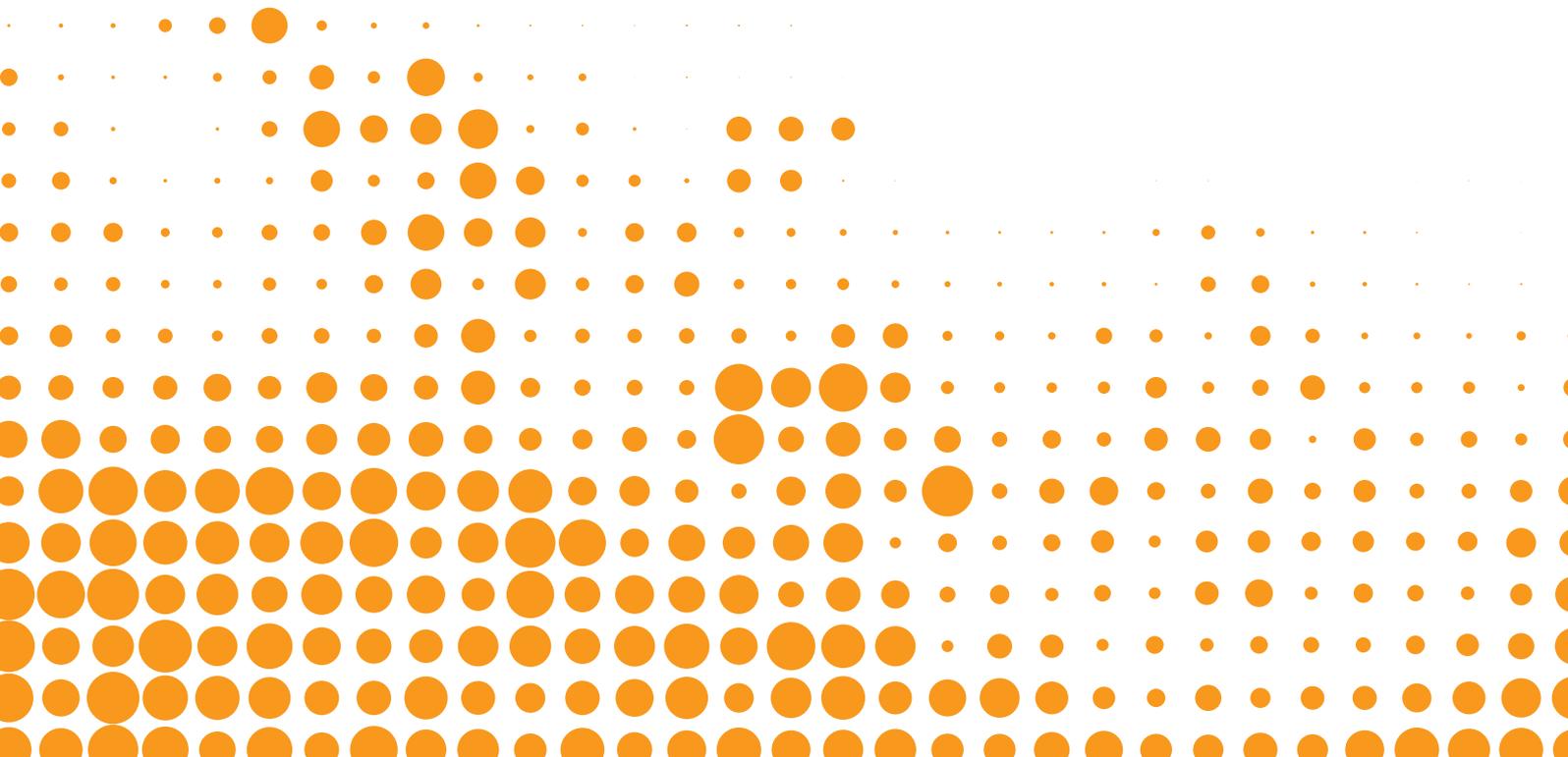


BEST PRACTICES FOR PLANNING A VACCINATION CAMPAIGN FOR AN ENTIRE POPULATION

THIS DOCUMENT IS A SUPPLEMENT TO “BEST PRACTICES
IN MICROPLANNING FOR POLIO ERADICATION”.



ACKNOWLEDGEMENTS

These best practices documents for polio eradication have been developed from the contributions of many people from all over the world. The people concerned have themselves spent many years striving to eradicate polio, learning from successes and failures to understand what works best and what does not, and quickly making changes to suit the situation. In writing these best practices the aim has been to distil the collective experiences into pages that are easy to read and detailed enough to be adapted for other health programmes.

'To strive, to seek, to find, and not to yield'

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INTRODUCTION

These best practices of vaccination campaigns for an entire population have been developed from experiences of polio vaccination campaigns conducted in the Congo, Namibia and Tajikistan. Basically, the activities expand on the planning elements used in polio vaccination campaigns for children, but are on a much larger scale and include effective social mobilization because adults are not usually part of vaccination campaigns. Delivery operations include fixed sites, house-to-house teams and transit teams.

Above all, to reach the entire population, the campaign’s timing and location must be convenient for local communities whose members are often at work during the day and should not have to travel long distances for access.

DELIVERY STRATEGY

Unlike dealing with young children who will mostly be at home, targeting an entire population means that 50–70% will not be in households during the day, but at work and outside in the streets and countryside. The main delivery strategy should therefore be fixed sites, followed by mobile and transit point teams and door-to-door follow-up, mainly conducted in the evenings when people will be at home.



PLANNING AND PREPARATION

Resource and logistics plan

Plans must be carefully developed and coordinated to capture the whole population. Because the true population numbers will likely not be known, the best approach is to add a population factor of 10–20%, especially in large urban areas.

According to the estimated workload, fixed site teams should be composed of:

- two people to vaccinate and mark fingers
- one person to record information on the tally sheet
- one person to mobilize/organize the crowd.

Door-to-door teams may consist of only two people.

Communications plan

- The whole population must be engaged through widespread media communication delivered by the community's most senior and respected health officials, who will explain in simple terms the reason for the campaign to ensure clear understanding and demand.
- Top-level administrators should inform all ministries, large companies, factories, businesses, universities, schools and religious centres, among others, in writing and include the dates and locations for vaccination.
- The ministry of education should be closely involved so school children can be vaccinated in school, class by class.
- All health personnel at every level should be informed on how the mass vaccination will be conducted, using various training and media opportunities.
- Persons responsible for communication should prepare frequently asked questions (FAQs), such as on the vaccination of pregnant women, infants and sick people, and any contraindications.
- Posters and leaflets should be widely distributed if sufficient time is available; they should be localized in content to inform communities when and where the vaccination will take place.
- Finger-marking will be applied to the whole population.

Preparation

Convenient locations and times

Operational coordination structures should be established at all levels with maps and schedules, and priorities and responsibilities should be made clear to all.

- Use maps to decide on convenient locations for posts.
- List every school, and assign teams to work in the schools.
- Distribute the maximum number of conveniently-placed teams at posts, easily accessible and visible at markets, health centres, railway stations, churches, headquarters of districts, businesses, factories, universities and major intersections, among others, to optimize access and capture the maximum number of people.



- Arrange for posts to be open at convenient times (during, before or after working hours).
- Request cooperation in organizing vaccination posts and managing crowds of clients.
- Request local support to facilitate the work of teams, providing staff awareness, visible and manageable sites, tables and umbrellas.

Operations

During the first 2–3 days (fixed posts)

- Keep posts open from early morning to late evening to access people going to and returning from work.
- Ensure schools have dedicated teams to work there class by class, with the close cooperation of school teachers.
- Deploy mobile vaccination teams in addition to fixed teams to regularly scan busy places and vaccinate those unimmunized.

Fixed post teams will have a very heavy workload when the entire population is being vaccinated, but vaccination will be much quicker because it mostly concerns adolescents and adults (over 80% of the population will be older children and adults).

After the initial 2–3 days

- Ensure a certain number of fixed teams continue working at the main places of concentration, such as markets, and railway and bus stations.
- Have house-to-house and mobile teams scan houses, offices and other places for missed persons.
- Ensure house-to-house teams miss no one, especially children aged under 5 years.
- Have house-to-house teams continue after working hours to find adults at home.

At the end of the vaccination operations

- Promote independent monitoring that uses established methods, such as lot quality assurance sampling (LQAS).

Operational issues

- A robust system for vaccine and logistics flow, including the provision of quick replenishment, should be planned.
- Social mobilization and communication must include appropriate strategies for generating awareness and demand.
- Team working hours should be adapted to market hours, working hours and public transport schedules, for instance, to allow vaccination of the entire population.
- All teams must start their working days with at least 1000 doses of oral polio vaccine (1500 for fixed teams) and three finger-markers (six for fixed teams). A marker is good for 300–400 markings.
- House-marking should be simplified to include the date of the visit and whether all occupants are vaccinated.
- The tally sheet should record children aged under 5 years separately from those aged over 5 years.



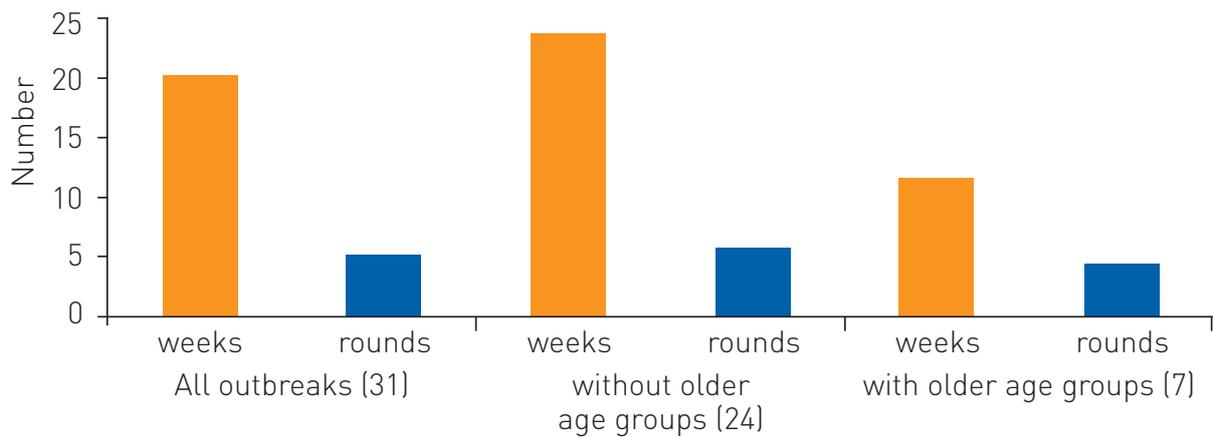
Conclusions

These conclusions are based on operational experiences of expanding the campaign age group to the whole population.

Polio campaigns extended to include the whole population have been used both in countries with and without adult transmission.

Data collected from outbreaks in the Congo, Namibia, Tajikistan, Somalia, China and the Democratic Republic of the Congo (DRC) show that including older age groups appears to have reduced the duration of polio outbreaks by weeks and the number of vaccination rounds required (Figure 1).

Figure 1. Mean duration of polio outbreaks with or without older age groups, 2011



On most occasions when the whole population was included, the number of vaccinated children aged under 5 years increased compared to campaigns aimed only at children aged under 5 years. Figure 2 shows a significant increase in vaccine uptake for children aged under 5 years when the whole population was included in the campaign.



Figure 2. Effect of campaigns involving the whole population on the number of vaccinated children aged under 5 years, 2011

Region	Number of vaccinated children aged <5 years		
	Strategy: <5 y	Expanded age group	Increase/decrease <5 y
Tanganyika (KAT)	534 532	659 506	23%
Kinshasa	1 764 229	1 892 847	7%
Popokabaka (BDD)	30 881	32 140	4%
Kikwit (BDD)	618 509	735 177	19%
Kimvula (BCG)	13 585	17 984	32%
Kasongo (MAN)	253 000	248 516	-2%
Congo Br	786 292	1 018 867	30%
CAR RS3	159 300	183 405	15%
DRC Kabondo VDPV area	380 566	488 588	28%

KAT: DRC; BDD: Bandundu DRC; BCG: Bas Congo DRC; MAN: Maniema province DRC; Br: Brazzaville; CAR RS3: ...; VDPV: vaccine-derived poliovirus





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