



# TECHNICAL REPORT

## Measles, Rubella, Polio and Vitamin A Vaccination Campaign



**Zaatari camp**  
**20-28<sup>th</sup> November 2013**



Dates	From 20 <sup>th</sup> to 28 <sup>th</sup> of November 2013
Target population	All Syrian refugees aged between 6 months and 20 years old in Zaatari camp, regardless of previous vaccination status (estimated population as of 24.11.2013 was 82000 people). The target population was 49200 based on persons aged from 6 months to 20 yo estimated at 60 % of total population (UNHCR data for Zaatari camp as of 24.11.2013).
Overall Campaign administrative coverage	45891 people vaccinated against measles/rubella = 93 % Administrative coverage by age group and interventions below: <ul style="list-style-type: none"> <li>- <b>Measles/Rubella :</b> 6 months to 59 months (19% of total)=15,880 = 101% coverage 6 years to 15 years (30% of total) = 22211 = 90 % coverage 16 to 20 years(10% of total) = 7800 = 95 % coverage</li> <li>- <b>Vitamin A :</b> 6 months to 59 months = 14053 = 90 % coverage</li> <li>- <b>Polio :</b> 0 to 59 months (20% of total) = 15319 = 93% coverage</li> </ul>
Number of vaccination teams, and supervisory teams	<ul style="list-style-type: none"> <li>- 28 vaccination teams (20 fixed teams and 8 mobile teams) with each team composed of 5 persons (one from MoH, one or two from IOM, 3 from IRD). The responsibilities were divided as follows: one vaccine preparatory and tallying person, one for injection, one for OPV administration and tallying, one for Vitamin A administration and tallying.</li> <li>- In addition, 2 crowd controllers, 2 finger markers and 6 community mobilizers were assigned for each vaccination site.</li> <li>- 6 supervisors, one for each vaccination site (MoH)</li> <li>- 1 cold chain controller (MoH)</li> <li>- 1 campaign coordinator (MoH)</li> <li>- 6 coordinator supporters (UNHCR, UNICEF, IRD, IOM)</li> </ul>
Number of health workers and volunteers who participated	<ul style="list-style-type: none"> <li>- 28 health workers from MoH + 40 from IOM for vaccinations and preparation of injections</li> <li>- 120 community health workers from IRD for polio/vit A</li> </ul>

	<p>vaccination, crowd control, finger marking and social mobilization</p> <ul style="list-style-type: none"> <li>- staff from NGO and agencies in the camp (Acted, JEN, Save the children, NRC, IRC, MSF, Oxfam...) for community communication and mobilization</li> <li>- 1 IMC staff for rapid convenience monitoring</li> </ul>
Results of other integrated child survival Interventions	<ul style="list-style-type: none"> <li>- vitamin A was provided to children between 6 and 59 months</li> <li>- Oral polio drops to all children between 0 and 59 months</li> </ul>
Experience regarding pre-campaign and campaign monitoring	<ul style="list-style-type: none"> <li>- <u>pre-campaign</u>: a timeline was established and sent to implementing partners during the 2 weeks before the campaign. Activities/achievements were then reported on daily basis. Harmonization and standardization training for MoH and IRD health workers. .</li> <li>- <u>during the campaign</u> : <ul style="list-style-type: none"> <li>.monitoring/supporting was done by field public health doctors from UNHCR and UNICEF, and field supervisors from IRD and IOM. They were visiting vaccination sites on daily basis, as well as following mobile teams, to check on organization, supplies, quality, and mobilization.</li> <li>. Quality monitoring checklists were distributed to all MoH supervisors by WHO staff at the beginning of the campaign.</li> <li>. A rapid convenience monitoring was done during the campaign, for each covered district</li> </ul> </li> </ul>
Comments on vaccine quality, injection safety and any AEFIs observed or Reported	<ul style="list-style-type: none"> <li>- There were no AEFIs observed or reported for vaccine quality and injection safety (see Unicef field monitors report)</li> </ul>
Comments on the experience with injection safety and Immunization waste Management	<ul style="list-style-type: none"> <li>- IOM and MoH vaccinators used safety boxes in an appropriate manner. However, many staff were recapping syringes after vaccination.</li> <li>- Medical waste collected everyday by each supervisor to be stored in MoH center in the camp. JHAS was collecting the medical waste from the MoH center to</li> </ul>

	dispose of it.
Estimated vaccine wastage	10%
Some qualifying comments about high-level political commitment	<ul style="list-style-type: none"> <li>- The campaign was strongly supported by MoH and all other relevant local authorities</li> </ul>
Were any hard-to reach children immunized? Give details of the areas and characteristics of the populations. Explain strategies employed	<ul style="list-style-type: none"> <li>- Hard to reach target groups including adolescents and disabled children and adults were immunized in their tents through the mobile teams mopping up strategy in all districts.</li> <li>- Before and during the campaign, all partners in the camp agreed to help in mobilization : youth centers and kindergarten would send the children to vaccination sites, hygiene promoters would spread the message door to door, mosques also deliver the messages 3 times/day/district to encourage people to get vaccinated.</li> <li>- Every day, 8 mobile teams would do mopping up in the 2 districts that were covered by fixed vaccination teams the day before. These mobile teams would go tent to tent, to reach all people who missed vaccination, especially young women who do not go out of their caravan easily, young men working outside and children with disabilities whose family found difficulty in taking them to the fixed vaccination sites.</li> </ul>
Was the campaign used to improve measles and/or polio surveillance	Yes, every suspicious case of measles or acute flaccid paralysis noticed by mobilizers or health staff in vaccination tent would be sent to the clinic. Every malnourished child would be directed to Save the children caravans in charge of MAM management.
Was the campaign used to improve routine immunization? Explain	<p>The campaign was used to :</p> <ul style="list-style-type: none"> <li>- Provide refresher training for all involved health workers in immunization practices, injection, waste management, logistics and cold chain management.</li> <li>- Build trust and awareness with the community on vaccination</li> <li>- Parents with children under 5 yo received key messages on routine immunization</li> <li>- MoH have agreed to avail EPI routine vaccination at 5 of the</li> </ul>

	camp health partners (MdM clinic 2, JHAS clinic, Saudi clinic already in place ; JHAS/UNFPA and MDM clinic 1 to start within 1 month)
Who were the major national/local partners	Ministry of Health, community health workers, religious leaders, street leaders, and all partners in the camp who helped in mobilization (IRD, Save the Children, IMC, IRC, NRC, FCA, Acted, JEN, Oxfam, MSF) as well as other UN sister agencies
Local resource mobilization (in cash and in kind)	MoH provided staffing, UNICEF provided the vaccines and some cold chain equipment, WHO supported stipends of MoH staff and transport, IOM provided staffing, IRD/UNHCR provided staffing and logistic support
Mop up immunization planned or completed? Give details	<p>After each vaccination day in one district, 8 mobile teams were deployed the day after in the same districts to reach, tent to tent, all people who missed the vaccine the day before.</p> <p>In addition, the very last day of the campaign was a mop-up day, 5 mobile teams would go on the 2 markets roads and 2 crowded districts to reach the non vaccinated people in the streets.</p> <p>After the campaign, each child under 5 yo who has not been vaccinated, could be sent to one of the three routine immunization centers.</p>
Coverage evaluation surveys planned/ completed? Briefly give details of methodology and results	<p>During the campaign, a rapid convenience monitoring has been conducted by UNHCR and IMC, starting the 3rd day of the campaign, in 2 “covered” districts per day.</p> <p>After 2 days of vaccination in an area (1 day with fixed teams and 1 day mop-up with mobile teams), the IMC and UNHCR staff would check the area by sampling 2-4 clusters based on the population density of the district surveyed. In each cluster, 10 tents were checked randomly for OPV and 10 for MR. In each of these tents, the team would check on vaccination status of one (randomly chosen) child found in the target group. If the patient had no finger mark to prove the vaccination, he was considered as non vaccinated. If he had the finger marked, he was considered as vaccinated. For each cluster if there was one child not vaccinated then the team returned to do another mop-up.</p>
Highlight major problems	- People from 15 to 20 years old are more difficult to

encountered	<p>reach (young men are working, young women don't want to be vaccinated by men in a "public" tent)</p> <ul style="list-style-type: none"> <li>- restricted vaccination schedules (from 9.30 to 1.30)</li> <li>- Mobile teams were very difficult to be motivated every day, complaining of getting tired/thirsty/hungry after 1 hour walking. We had to walk with them every day to keep them working well</li> <li>- Still lack of quality in the tally sheets reporting : discrepancy between data for the similar age ranges e.g. between Vitamin A and Polio. Some teams reported number of people receiving Vitamin A more than Polio (although it should be polio more than Vitamin A)</li> </ul>
Highlight major achievements	<ul style="list-style-type: none"> <li>- Good inter-sectoral support from all partners during preparation for the campaign to help with communicating messages and mobilizing the community (through activities, schools, hygiene promotion, posters...)</li> <li>- Good cooperation and close collaboration between different organizations staff working in the campaign (MoH, IOM, IRD, UNICEF, UNHCR)</li> <li>- Optimization of vaccinations by sending mobile teams to all schools, youth and children centers</li> <li>- Effective mop-up done tent to tent by mobile teams on daily basis to reach all hard-to-reach people</li> <li>- Conducting the rapid convenience monitoring</li> </ul>
Highlight major lessons learnt	<ul style="list-style-type: none"> <li>- All actors involved in the campaign should receive the same training. IOM staff didn't come to the training because they are doing vaccination on arrivals, and thought they didn't need it. But the age range for vaccines was not the same, and as the staff was not trained, we had to solve many issues the day of the drill.</li> <li>- All MoH supervisors should be medical staff with strong experience in vaccination, to be able to check on quality issues, compile data from tally sheets and answer patients questions about contra-indications and</li> </ul>

	<p>side effects.</p> <ul style="list-style-type: none"><li>- Some discrepancies appeared in the tally sheets for nearly all teams, so we will really have to insist on the importance of tallying for the next campaign.</li><li>- People between 15 and 20 yo are more difficult to reach because boys/men are working, girls/women are afraid of lack of privacy in vaccination tents, and youth are often afraid of needles, convinced that they are already vaccinated or don't need it as adults, rumors about poisonous vaccines...</li><li>- Mobile teams felt demotivated very quickly, refusing to walk in the camp because of the lack of comfort and tiredness. All staff should know in advance that they would need to go walking to reach as many people as possible.</li><li>- Mobile teams are essential to reach hard-to reach people, such as disabled, youth reluctant and refusing vaccines.</li><li>- Strategic sites can be used to reach more youth from 16 to 20 yo such as market roads, distribution areas, youth centers.</li></ul>
--	--