health

Department:
Health
REPUBLIC OF SOUTH AFRICA

INTERGRATED NATIONAL MEASLES AND HUMAN PAPILLOMAVIRUS VACCINATION CAMPAIGN

06 FEBRUARY TO 31 MARCH 2023

Love them, feed them, protect them, immunise them!

FIELD GUIDE

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ACRONYMS

AEFI	Adverse Event Following Immunization
ACSM	Advocacy, Communication and Social Mobilisation
bOPV	Bivalent Oral Polio Vaccine
CBO	Community Based Organizations
CPR	Cardiopulmonary Resuscitation
DCST	District Clinical Specialist Team
DHIS	District Health Information System
DOH	Department of Health
EPI	Expanded Program on Immunization
EPI-SA	The Expanded Programme on immunisation in South Africa
HISP	Health Information Systems Programme
HIV	Human Immune Deficiency Virus
HPV	Human Papillomavirus
IEC	Information, Education, Communication
IU	International Units
IV	Intravenous
NGO	Non-governmental organisation
ODK	Open Data Kit
PHC	Primary Health Care
PN	Professional Nurse
RNA	Ribonucleic Acid
RtHB	Road to Health Booklet
SIA	Supplemental Immunisation Activities
STH	Soil Transmitted Helminths
UNICEF	United Nations International Children’s Emergency Fund
VAD	Vitamin A Deficiency
VVM	Vaccine Vial Monitor
WHO	World Health Organization

1. Background

Disruptions of routine immunisation services brought on by the Covid 19 pandemic has worsen the longstanding challenges in vaccine preventable disease (VPD) surveillance performance. From Jan to July 2022, reported positive measles cases are three times higher than the pre-Covid-19 years with the highest measles incidence rate of 1.4. The target for measles incidence rate is ≤ 1 case per 1,000,000 populations and historically this rate ranges between 0.3 to 0.8 when there is no reported outbreak during the same reporting period.

Considering the rise of accumulation of positive measles cases since January 2022, the recent measles outbreak in Gauteng and ongoing outbreaks in neighbouring countries, put South Africa at the brink of experiencing national measles outbreak if measures are not in place to improve measles vaccination uptake. It is also worth noting that Gauteng has experienced measles outbreak in May 2022. Reflecting on the experience of the 2009 and 2017 measles outbreaks, this indicates the urgent need for national measles campaign during the 2022/23 financial year (FY) to achieve the elimination goal.

With the suboptimal coverage levels in measles vaccination, Limpopo province experienced measles outbreak from October 2022, which spread to Mpumalanga, Gauteng, Free State and North West provinces. The most affected age group is 5-9 years which led to the measles outbreak response vaccination extended to under 15 years of age. Limpopo conducted measles vaccination campaign by vaccinating children 6 month to 59 months, while all other affected provinces vaccinated children up to 15 years.

The National Department of Health, supported by World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), National Institute for Communicable Diseases (NICD), Clinton Health Access Initiative (CHAI) and other stakeholders and partners, supported the outbreak response teams to further curb the spread of measles outbreak.

The nationwide mass measles supplementary immunisation activities (SIA)/ campaign will still take place as planned in February 2023. The campaign will be executed nationally using fixed, outreach and mobile vaccination sites. A comprehensive advocacy, communication and social mobilisation strategy will be implemented to reach all eligible children, including the never reach communities. Furthermore, the measles campaign is now extended to overlap with the annual Human Papillomavirus vaccination of grade 5 girl learners in schools, planned for 20 February to 31 March 2023. If all plans are in place districts and provinces can fully integrate the two campaigns to start from the 06 February to 31 March 2023, to include learners in schools, up to 15 years old.

- **The purpose of this field guide is to assist vaccinators, supervisors and other health workers involved in the mass measles and HPV vaccination campaign: to plan, implement, supervise, monitor, and evaluate the campaign.**
- **It focuses on key issues that are of importance for effective implementation of the vaccination campaign.**

2. Purpose of the mass vaccination campaign

2.1. To raise population immunity to a high level that ensures prevention of disease outbreaks by administering additional measles dose to all children under 5 years old regardless of their previous history of measles vaccination. Use measles campaign as a platform for providing Vitamin A supplementation and Deworming medication.

2.2. Limpopo province experienced measles outbreak in October 2022, and spread to Mpumalanga, Gauteng, KwaZulu-Natal and North West provinces and mainly affected children 5-9 years of age. These provinces conducted measles outbreak response by vaccinating children 6 month to 59 months in Limpopo while all other provinces vaccinated children up to 15 years old.

2.3. However, the outbreak could not be contained with all these measures, and it was recommended that the planned measles campaign overlap with the annual Human Papillomavirus (HPV) vaccination campaign for grade 5 girl learners in schools, planned for 20 February to 31 March 2023.

3. Target Population

3.1. For measles vaccination, all children from 6 months to under 15 years, in and out of school, regardless of their measles vaccination status, and previous measles doses received, are eligible.

3.2. HPV vaccination will only be administered to grade 5 girl learners aged 9 years and older in schools.

3.3. Diphtavax, Td will be administered to grade 5 boys and girls in schools aged 9 years and older in Limpopo province only due to short, dated Td vaccines.

3.4. For Vitamin A, the target is all children missing their routine doses (catch-up) up to 59 months.

3.5. For deworming, the target is all children missing their routine doses (catch-up) up to 59 months.

4. Dates for the campaigns

4.1. 06 February to 31 March 2023, for the integrated national measles and HPV vaccination campaign, including Td vaccination in Limpopo province only.

NB: The mass measles vaccination campaign will be conducted as a one round of one dose for all children from 6 months to under 15 years of age.

4.2. 02 May, June, and 31 July 2023: National School Deworming Programme (NSDP) for Grades R to 7, in quintiles 1 to 3 schools.

4.3. 04 September to 31 October 2023: second dose HPV vaccination including Td vaccination for grade 5 boys and girls in schools, in all provinces expect for Limpopo.

4.4. 16-29 October 2023: School Health Week offering comprehensive onsite health services for learners.

5. Vaccination Coverage

5.1. All districts and provinces are expected to reach at least 95% of measles coverage. Targets are based on absolute numbers.

5.2. An assessment of campaign resources and partner engagement needs to be detailed in district micro plans, submitted to provincial level for consolidation and submitted to national for analysis.

5.3. Vitamin A and deworming, all districts are to reach 80%. Targets for Vitamin A and Deworming are based on number of children missing routine dose.

5.4. HPV vaccination campaign targets of 80% learners and 80% schools are based on the 2022/23financial year approved provincial Business Plans and Conditional Grant budget allocation.

6. Microplanning and logistics

Microplanning is a **"bottom-up"** process of detailed planning carried out to determine the local needs for the CAMPAIGN/supplementary immunisation activities (SIA)s to identify what is available and what is missing to ensure the smooth and satisfactory campaign implementation. It entails the inclusion and engagement of the communities affected by inequities in the process (e.g., through estimation of population size, mapping of communities and local stakeholders, social mobilisation, canvassing, etc.).

6.1. Developing microplan

Micro planning ensures:

- **Area map:** To reach all geographical areas and all communities, never reached by campaign.
- **IEC plan:** Community awareness, demand, and utilisation
- **Human Resource Plan:** Availability of appropriate and trained human resources.
- **Monitoring plan:** Quality and completeness through supervision and monitoring
- **Logistic plan:** for timely delivery of vaccines & other logistics
- **Cold Chain plans:** Proper vaccine storage, distribution, and management
- **AEFI management plan:** Adverse Events Following Immunisation reporting and management.
- **Waste management:** Safe disposal of immunisation waste

6.2. Operational plan for the campaign components:

- target population estimates, broken down by sub-districts and health facilities.
- percentages of population in rural and urban areas.
- lists and descriptions of zero-dose communities, hard-to-reach areas and special populations, and suggested strategies to reach them (this is critical as it is often these groups that are missed by the RI programme and in most need of vaccination).
- number of staff needed by category, available and staffing gaps (health staff, volunteers, supervisors, monitors, drivers);
- daily data aggregation, reporting and analysis. Responsibility for each component should be assigned to a specific person.
- vaccine, cold chain, transport, and logistics management.
- waste management.
- AEFI monitoring.
- Training and capacity building.
- social mobilisation and communication.
- strategies for implementation; and
- list and description of resistant/hesitant groups, and suggested strategies to reach them.

7. Validation of microplan

It is important that micro plans are validated at each level as data are collected. This calls for effective supervision of the development of each microplan. Once microplan from the health centre-level reach the district, they are consolidated by the district

coordinators to include district-specific costs (e.g., supervision, meetings, transport etc.) before forwarding the information to the provincial level, then to national level.

8. Training

Detailed planning for training should determine the training needs by assessing the knowledge and skill gaps of the health workers. The provincial and district master trainers shall use standardised training materials from NDOH to train sub-district-level staff down to local CAMPAIGN vaccinators and volunteer.

Steps to ensure high quality training.

8.1 The number of cascade levels is limited to two (i.e., national-level master trainers train the provincial and district mid-trainers 8 weeks before the CAMPAIGN, and mid trainers directly train the supervisors, health workers and volunteers 2 weeks before the CAMPAIGN). Therefore, all target trainees should be trained 2 weeks before the CAMPAIGN.

8.2 Availability of standard agenda and training materials (guidelines and specific training hand-outs, electronic updated training materials/videos) to ensure consistency of information and training at all levels.

8.3 Closely monitor and evaluate the training quality as it moves down the levels to maintain the strength and consistency of key messages.

8.4 Carry out tests before and after the training to evaluate its effectiveness.

9. Advocacy, Communication & Social Mobilisation

During the planning, implementation and monitoring phases, integrated activities in the form of advocacy, communication and social mobilisation will play a key to a successful mass measles vaccination campaign.

Strategies for Advocacy and Social mobilisation.

Using variety of channels which include meetings between various levels of government such as Department of Basic Education (DBE) and Department of Social Development (DSD), civil society organisations (CSO)s, news coverage to ensure commitment at all levels for effective campaign implementation. Strategies include but not limited to the followings:

9.1. The use of high placed officials and political leaders at national and provincial levels (MEC for Health, Head of Departments etc.)
9.2. Sensitisation of political, religious, cultural leaders and councillors.
9.3. Information, Education and Communication (IEC) material in English and other local languages.
9.4. Conducting health education sessions at all health facilities.
9.5. Involvement of the local private health sector, other departments, NGOs, CBOs and volunteers in planning and implementation of the Campaign.
9.6. Involvement of local schools and churches in community mobilisation.
9.7. The use of community meetings and Imbizos to create the Campaign awareness.
9.8. Conducting door-to-door mobilisation to disseminate key preventative child health services messages and if there is poor response, repeat during the Campaign if the coverage is low.
9.9. The use of loudhailers to spread the word amongst the communities.
9.10. Rapid response to false/ bad rumours

10. Communication channels/ tools

10.1. Electronic Media:

- Media briefing
- Television, interviews, and scripts
- Public service announcements on TV and radio
- Internet – Websites, Intranet, Facebook and Twitter and Email lists

10.2. Print material:

- Media release and editorial in newspapers
- Posters with venue and dates, displayed at different vaccination posts.
- Fact sheets, leaflets, stickers, brochures, and banners in different local languages
- Articles in magazines, health journals and newsletters

11. Others:

- **Edu mobiles to visit clinics** across the country.
- Talk and radio shows.
- Use of loudhailers
- Rapid response to rumours against vaccination: A Rapid Response Team to address false rumours to be set up during provincial planning meetings and their contact particulars provided to facilities and vaccinators.

12. Effective communication activities

- Use epidemiological and measles data to prioritise and direct ACSM activities, e.g., high number/proportion of unimmunised children, hard to reach areas and special populations.
- The campaign will also be located within the national Side-by-Side campaign's pillar of protection and its partners, including Ilifa Labantwana.
- To sustain community demand for vaccination services during this unique period, a tailored communication strategy will be implemented to provide accurate health information, address community concerns, enhance community linkages and encourage continued use of immunisation services.

Table 1: Demand creation activities for ACSM

Elements of the plan	Activities within the element	National	Provincial	District	Facility	Partner
Mass Media Element	National TV Adverts					
	Conceptualisation	x				x
	Resource Mobilisation	x				x
	Production and flighting	x				x
	M&E and reporting	x				x
	National and Region Radio Programme					
	Conceptualisation	x	x			x
	Resource Mobilisation (including human resource in the form of content experts)	x	x	x		x
	Production and flighting	x	x	x		x
	M&E and reporting	x	x	x		x
	Local and Community Radio and TV Programme					
	Conceptualization	x	x	x	x	x
	Resource Mobilization (including human resource in the form of content experts)	x	x	x	x	x
	Production and flighting	x	x	x	x	x
	M&E and reporting	x	x	x	x	x
IEC Material Element	Print Media IEC Material					
	Development, printing, and Distribution of Immunisation catch up schedule.	x				x
	Development and distribution of	x	x	x	x	x

Elements of the plan	Activities within the element	National	Provincial	District	Facility	Partner
	immunisation promotion newspaper article					
	Translation in to 10 official languages and distribution of EPI poster	x	x	x	x	x
	Development of EPI APP	x				x
	Digitalization of IEC Materials and stationery (Health Care worker Video, EPI Catch up schedule, Vaccinators Manual, etc)	x				x
	Development and distribution of social media content	x	x	x	x	x
Community Engagement and outdoor activities Element	Child health- Health Promotion activities		x	x	x	x
	Community and stakeholder engagements		x	x	x	x

13. Operation of vaccination posts

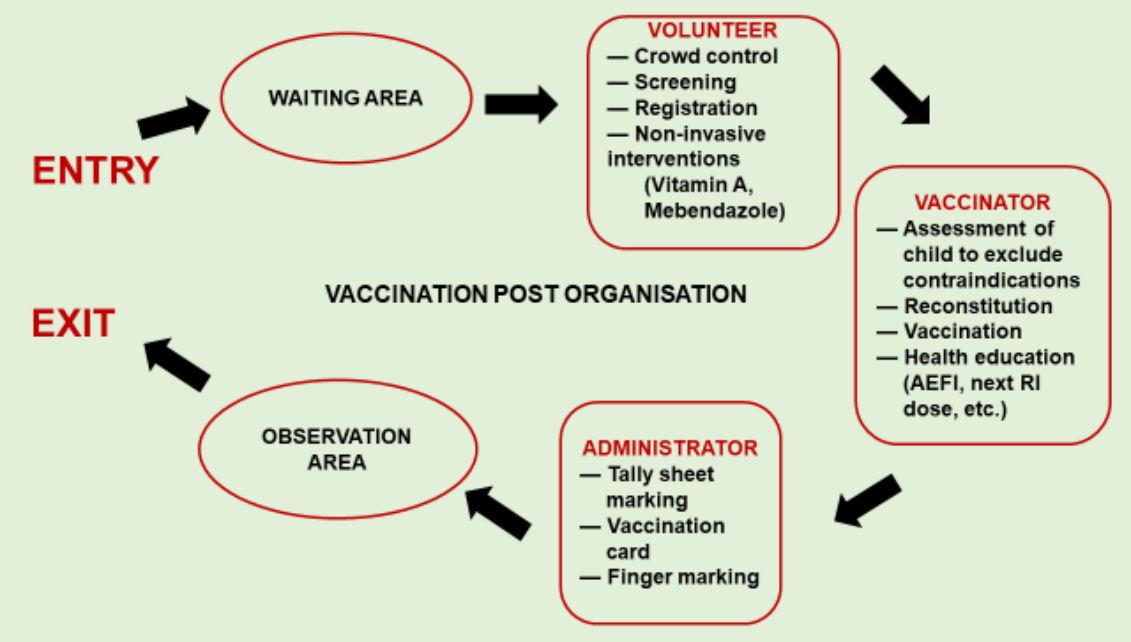
13.1. Roles of personnel

Each team should ideally consist of:

- **Team leader** - a professional nurse responsible for management of the immunisation post.
- **Vaccinator** – a professional nurse (PN) who is responsible for administration of the vaccine. However, staff/enrolled nurses could be included to assist the PN to vaccinate children under direct supervision. The vaccinator who is a professional nurse may be the same person as the Team leader.
- **Administrators** – a clerk or a volunteer or any other person who will be responsible for keeping record of all clients seen and recording the doses administered.
- **Health Promoters** – this category of staff includes Community Health Workers and community members responsible for the mobilisation of the community to participate in the immunisation drive activities.
- **Volunteers** – to assist with accurate recording and tallying of campaign doses administered and to ensure order/workflow at the immunisation point.

13.2. Campaign posts

- Each vaccination post should be clearly marked (e.g., poster, banner, flag) and volunteers and health workers should be easily identifiable (uniform, name tag, etc.). A well-functioning post should ensure an efficient one-way traffic flow to prevent bottlenecks, long waiting periods and confusion.



13.2.1: Fixed post and satellites: This is a health facility where a vaccination team is based and the measles campaign is administered. These include clinics, community health centres, gateway clinics and specialist clinics like paediatric outpatient departments in hospitals. Children with underlying medical conditions that are considered to be at high risk will be targeted at paediatric outpatient departments and specialist clinics. Provinces will have to include in their micro plans how they plan to sensitise physicians in hospitals and how they will ensure that these children are reached.

13.2.2: Mobile Service: This is a team travelling in a vehicle/mobile clinic that moves from one point to another, on a defined daily route, administering MEASLES and other interventions as appropriate.

13.2.3: Outreach Services:

13.2.3.1: This service will include visits to Crèches, Nursery Schools, Day Care Centres, Orphanages and Children's' Homes. Teams will visit a crèche or day care centre to immunise eligible children.

13.2.3.2: Private health care providers should be involved in the MEASLES campaign. Provinces need to include in their micro plans how they will work together and ensure the supply of vaccines to private health care providers.

Note: Immunisation teams should remind the community about the importance of routine immunisation.

14. Consent process

- Written informed consent is required for all the measles and HPV vaccination campaign activities at institutions such as crèches, preschools, children's homes and day care centres and schools where parents or caregivers are not present during the service delivery. At all other posts where parents, caregivers bring the children for immunisation, written consent is not required - consent is implied by bringing children for vaccination.

- **Before any intervention or procedure is done; ensure that the written consent form is signed indicating informed parental/caregiver consent.**
- **<u>No procedure</u> should be done without a written informed consent form at any post where the care giver/parents are not available**

15. Checking of the Road to Health Booklets

15.1 Measles vaccine

- During the campaign, the measles vaccine will be given to all targeted children irrespective of the child's current vaccination status. However, heath worker should always check for any other missed intervention on the Right to Health Booklet (RtHB) and referred appropriately.

  Two types of measles vaccines will be available from Biovac, namely the Measbio vaccine® and the Measles Vaccine Live attenuated SII/Cipla®. The Measles Vaccine Live attenuated SII/Cipla® is registered to be co-administered with any vaccines.

  During the outbreak response and national measles campaign the Measbio vaccine® may be co-administered with the human papillomavirus (HPV), Tetanus/reduced diphtheria (Td), and Comirnaty® (Pfizer COVID-19) vaccines. The World Health Organization (WHO) recommends that Measbio vaccine® can safely be co-administered with other vaccines from 9 months of age. Therefore, for the outbreak response and national measles campaign both the Measles Vaccine Live attenuated SII/Cipla® and Measbio vaccine® can be co-administered with the

vaccines required in children 9 months and older including but not limited to HPV, Td and Comirnaty® (Pfizer COVID-19) vaccines where applicable.

- **MeasBio® scenario examples:**
- **Baby attending for 6 months measles: provide the measles booster and request the parent/carer to return in 4 weeks for the routine measles.**
- **Baby attending for 9 months PCV (3): provide the PCV (3) AND the measles booster and request the parent/carer to return at 12 months for measles routine dose.**
- **Baby attending for 12 months measles: provide the measles booster and request the parent/carer to return in 4 weeks for the routine dose.**
- **Zero-dose children over 6 months, but under 9 months, provide the measles booster and request the parent/carer to return in 4 weeks to start catch-up.**
- **Zero-dose children over 9 months, provide the measles booster and start catch-up.**

15.2. Vitamin A supplementation and Deworming medication

- Check the RTHB to check if the child has already received eligible dosage of VITAMIN A and Deworming tablets. If yes, DO NOT administer another dose of VITAMIN A and Deworming tablets but thank and commend the parent/caregiver for ensuring that the child's health routine health intervention status is up to date. If the child missed any dose of Vitamin A and Deworming tablets, then administer the catch-up dose. Record the dose/s received on the RTHB.

  NB: Children presenting at the vaccination sites without the RtHB during the campaign.

INTERVENTION	AGE	WHAT TO DO?
Measles vaccine	6 months to under 15 years old	Give additional dose
Vitamin A	6 - 59 months	Give catch-up/missed dose
Deworming tablets	12 - 59 months	Give catch-up/missed dose
Deworming tablets	5 years to under 15 years old	Give 500mg Mebendazole

NB: HPV vaccination given only to grade 5 girl learners in schools.

16. Safe measles vaccine administration

Q: Who can administer the measles vaccine?

A: The measles vaccine should be administered by a professional nurse (PN) or an enrolled nurse under direct /indirect supervision of a PN.

16.1 Vaccine reconstitution

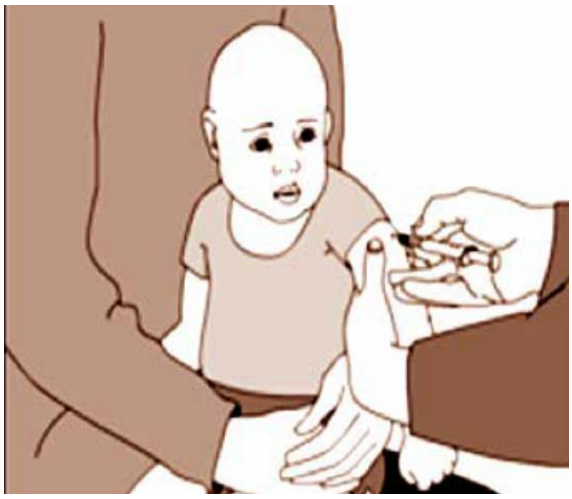
- Ensure that vaccine vials are issued with an equal number of diluent vials.
- Verify that correct vaccine and diluents (from the same manufacturer) are included.
- The vaccine and diluent must be stored at 2°C to 8°C; or the diluent must be stored between 2°C to 8°C; for at least overnight (± 12 hours) prior to use.
- Check the **expiry date** and the status of the **Vaccine Vial Monitor** (VVM) before reconstitution.
- Do not use vaccine if the expiry date has passed or the VVM reached discard stage.
- Reconstitute one vial at a time, mark with the date and time of reconstitution, and when not in use put it in the vaccine carrier/cold box.
- Use a sterile 5ml syringe and 19g needle to reconstitute each vial of measles vaccine with the supplied diluent. Use full contents of the diluent vial to reconstitute the measles vaccine.
- **Do not shake (this will cause frothing):** However, rotate the vial between palms of hands after reconstitution.
- Use a new reconstitution syringe for each vial of vaccine and diluent.
- Discard used 5ml syringe immediately in sharps container. ***Do not recap***.
- **DO NOT PRE-FILL SYRINGES**
- ***NEVER*** *carry and use reconstituted vaccine from one session site to another.*

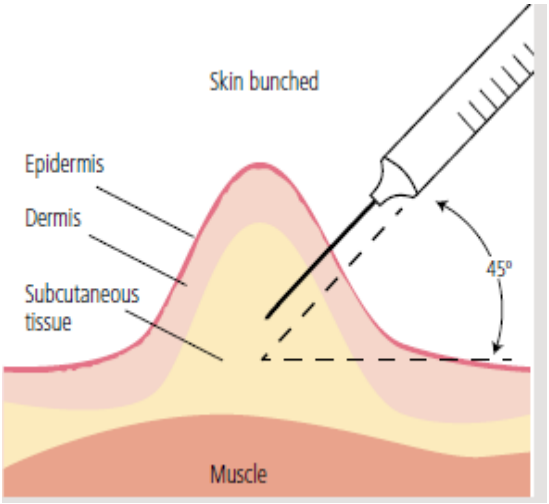
16.2 Measles vaccine administration

- **Use the same sterile needle and syringe to withdraw the vaccine and to administer the injection.**
- **DO NOT pre-fill syringes.**
- **Never leave the needle and syringe in a vial**
- **. DO NOT use Alcohol and Spirits to clean injection site, use clean water instead.**

- 0.5ml **subcutaneously** in the lateral aspect of the thigh (right) in 6 months to 11 months' infants and **subcutaneously** in the right arm in infants 12 months and up to under 15 years of age.
- Use an unopened 2ml syringe and 29g needle for each measles injection.
- If not enough vaccine for one complete dose is left in the vial, discard that vial, and take the complete dose from a new vial.
- Hold the child's upper arm from underneath; reach around the arm with your fingers to pinch up the skin.
- Clean injection site **with clean water on a cotton swab,** to remove visible dirt (add soap if obviously dirty) before vaccination.
- Ensure that the child is held securely.
- Push the needle into the pinched-up skin to a depth of not more than 1 cm. The needle should go in at a sloping angle (45 degrees).

- **THE MEASLES VACCINE SHOULD BE ADMINISTERED SUBCUTANEOUSLY**





- Press the plunger with your thumb to inject the vaccine.
- Withdraw the needle and press the injection site with a dry swab; ***Do not rub*.**

16.3 Human Papillomavirus (HPV) vaccine administration

- Sit the girl down on a chair to calm them and to minimise pain from the two injections.
- Clean injection site **with clean water on a cotton swab,** to remove visible dirt (add soap if obviously dirty) before vaccination.
- Administer 0.5ml of HPV vaccine **intramuscularly** in the deltoid region of the upper left arm.

When co-administered with measles vaccine to the grade 5 girls, administer on the right arm / opposite from the HPV vaccination to distinguish in case of AEFIs.

- Push the needle down at 90-degree angle, intramuscularly.
- ***NB: DO NOT ADMINISTER THE HPV VACCINE SUBCUTANEOUSLY, INTRADERMALLY, OR INTRAVENOUSLY***

17. After vaccine administration

17.1 Measles vaccine

- Discard used 2ml syringe in sharps container immediately after use. ***Do not recap.***
- Never leave the needle and syringe in a vial
- Vaccine spills should be cleaned with an appropriate antiviral disinfectant.
- Wash your hands with soap and water before and after the vaccination session.
- Mark left ring finger of the child with indelible marker pen. To prevent the marker pens from drying, recap them after every use and keep them horizontal when not using.
- Record each dose administered on the **Measles Daily Tally Sheet** by crossing out the next numeric square for each dose administered.

17.2 HPV vaccination

- Immediately discard the used syringe and needle as one unit into the sharp's disposal container. Do not dislodge the needle from the syringe.
- Do not recap the needle.
- Sign the vaccination card and ensure it is correctly recorded against the right girl on the vaccination register.
- Ensure that the correct batch number is recorded on the vaccination card.
- Thank the girl and give the date of the next dose.
- Ask her to sit for 15 minutes to observe that she does not feel dizzy or have other serious symptoms.
- Wash hands or spray with antiseptic spray before attending to the next client.

17.3 After the vaccination session

- At the end of the day, return all unused vaccines to the facility.
- Ensure all unused vials are returned to the fridge immediately.
- Place all the unused vaccine vials in the "returned" container, this is to ensure that the returned is used first.
- Complete the stock card indicating the number of vials returned.

- Return the cold packs to the freezer.
- All wastage (broken, expired VVM, frozen vials) is recorded on the stock card and reported.

18. Safe disposal of safety boxes

- All used disposable syringes and needles (including reconstitution syringes and needles) must be disposed of immediately after use – without recapping –into designated safety boxes provided in all vaccination posts.
- Dispose all needles and syringes in a sharp's disposal container immediately after use. **It is important to handle sharps waste properly to prevent health and environmental hazards.**
- To ensure safe handling and disposal of sharps containers:
  - Do not recap the needles before disposal into the container.
  - Do not handle or shake the sharps container more than necessary. Never squeeze, sit, or stand on sharps containers.
  - Never fill sharps containers more than ¾ full, or above the "full line" of the container as this increases the risk of needle-stick injuries.
  - Only used vials, needles and syringes must be discarded in the marked yellow sharps containers.

Q: What is the expected measles vaccine coverage?

A: 95% coverage in all districts

19. Measles vaccine: information to caregivers

- Inform the caregiver that after vaccination the child may experience pain and mild swelling on the injection site; that the child may experience a mild fever and in rare cases might develop a rash. Inform caregiver to contact the nearest health facility with any concerns post-vaccination. Ask the caregiver to remain with the child at the session site for 15 minutes after injection, preferably seated (to observe in case of AEFI with rapid onset).
- **NB: At schools, encourage educators to report AEFI to the school health team.**

20. Administering Vitamin A

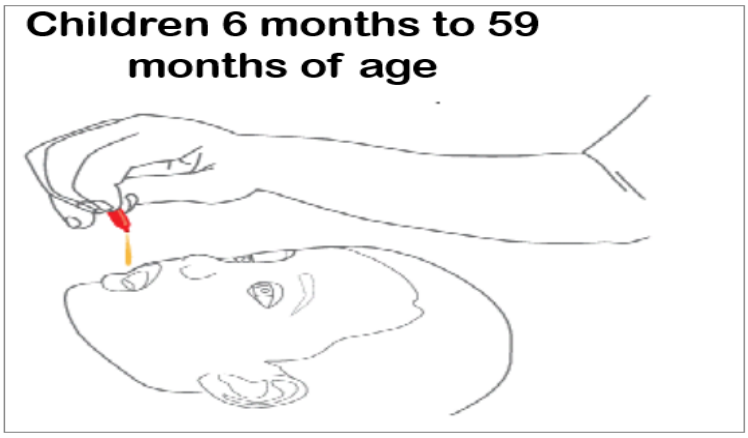
- As each child arrives, find out his/her age group (the target for the catch-up is 6 -59 months)

Q: Who can administer the Vitamin A capsules?

A: The Vitamin A capsule can be administered by the following: professional nurse, enrolled nurse, enrolled nursing assistant, dietician, nutritionist, trained community health workers.

Age	Vitamin A dose
6 to 12 months	Administer single dose of 100000IU
12 to 59 months	Administer single dose of 200000IU

- Ensure that hands are clean before commencing procedure.
- Using scissors, cut open the tip of vitamin A capsule (Each post will need scissors to open the capsules; using teeth, pins, or razor blades to open capsules is **NOT** recommended).
- Squeeze out the drops into the child's mouth.



- Discard all used vitamin A capsules in a red plastic bag.
- Put one mark on the tally sheet for each child given vitamin A.
- Record in the road to health booklet to show that the child has received vitamin A

Q: What is the expected coverage with Vitamin A?

A: 80% coverage in all districts

- **Do NOT** ask children to swallow capsules.
- **Do NOT** give capsules to caregivers to take away.
- Capsules should be kept dry and out of direct sunlight.
- Capsules should NOT be frozen. Vitamin A supplements do not need cold chain and do NOT need to be stored in a refrigerator.

- (If the capsules have come directly from a cool place, they may need to be warmed to room temperature by leaving the container open for a short time before a campaign session - the gelatine coat of capsules can become quite hard when cold.)
- A bottle of vitamin A capsules, if unopened, will keep its potency under good storage conditions for at least two years. However, once a bottle containing vitamin A capsules is opened, the capsules should be used within one year.

21. Administering Mebendazole tablets

Ask for the road to health booklet to determine the child's age or ask for the child's age from the care giver. Do not give deworming tablets to children under 12 months old.

Q: Who can administer the Mebendazole tablets?

A: Mebendazole can be administered by the following: professional nurse, enrolled nurse, enrolled nursing assistant, student nurses; dietician, nutritionist, trained community health workers and educators in schools

- Give the missed dose as follows:

Age	Mebendazole		
	Suspension (100mg per 5ml)	Tablet (100mg)	Tablet (500mg)
12 - 24 months	5ml twice daily for 3 days	One tablet twice daily for 3 days	
24- 59 months	25ml as single dose	Five tablets as single dose	One tablet as single dose

- Mebendazole tablets are chewable.
- Record on the RtHB
- Record each dose administered on the de-worming Tally Sheet (Mebendazole) by crossing out the numeric square for each dose administered.
- Advise the care giver to bring the child for the next routine deworming. In addition, alert the caregiver that child may pass worms in stool after administration of the Mebendazole if the child already had worm infestation prior to administration.

- **Always** check the expiry dates before use.
- **Avoid** exposure to heat.

- **In rare cases where an eligible child presents for deworming; and the child has challenges swallowing because of a disability e.g., cerebral palsy etc.; health care workers should dissolve the Mebendazole tablet in about 2mls of water and administer to the child.**
- **If the health care worker is still unsure how to handle this situation; they should refer the child to a senior professional e.g. DCST Paeds or paediatrician**
- **If a child spits or vomits after receiving the dose, it must be repeated**

Q: What is the expected coverage with Mebendazole?

A: 80% coverage in all districts

PLEASE NOTE

A SEPARATE CAMPAIGN STOCK CARD MUST BE USED FOR EACH SUPPLY RECEIVED FOR THE CAMPAIGN.

- **ROUTINE AND CAMPAIGN STOCK MUST NOT BE MIXED.**
- **THERE SHOULD BE CAMPAIGN STOCK CARDS FOR THE MEASLES VACCINE**

22. Disposal of medical waste

- All used masks and other personal protective equipment (PPE), used cotton wool and gauze, must be disposed of in the medical waste containers suitable for

biohazardous material. Similarly, all materials used to clean and decontaminate vaccine spills with disinfectant should be disposed of in medical waste containers. Medical waste containers must be sealed when full. Keep sealed medical waste containers in a dry and safe place, out of reach of children and the public, until they have been safely disposed of/collected by the approved company. Always segregate waste at generation points and follow the Waste Management and Healthcare Risk Waste disposal protocols. Ensure the contract for healthcare risk waste is in place and extended to accommodate the campaign waste management.

23. Reporting of an AEFI

- All adverse events following immunisation (AEFI)s should be reported immediately by telephone or fax to the district surveillance officer who will then contact the Provincial Coordinator. The information will be forwarded to the National AEFI coordinator. AEFI reporting forms must be available at all immunisation posts. The Programme Manager in each district is responsible to ensure timely reporting of all adverse events. AEFI should be reported through the Med Safety App or using the paper-based case reporting form (CRF). All minor, severe/serious AEFI/AESI and cluster of events should be reported within 24 hours

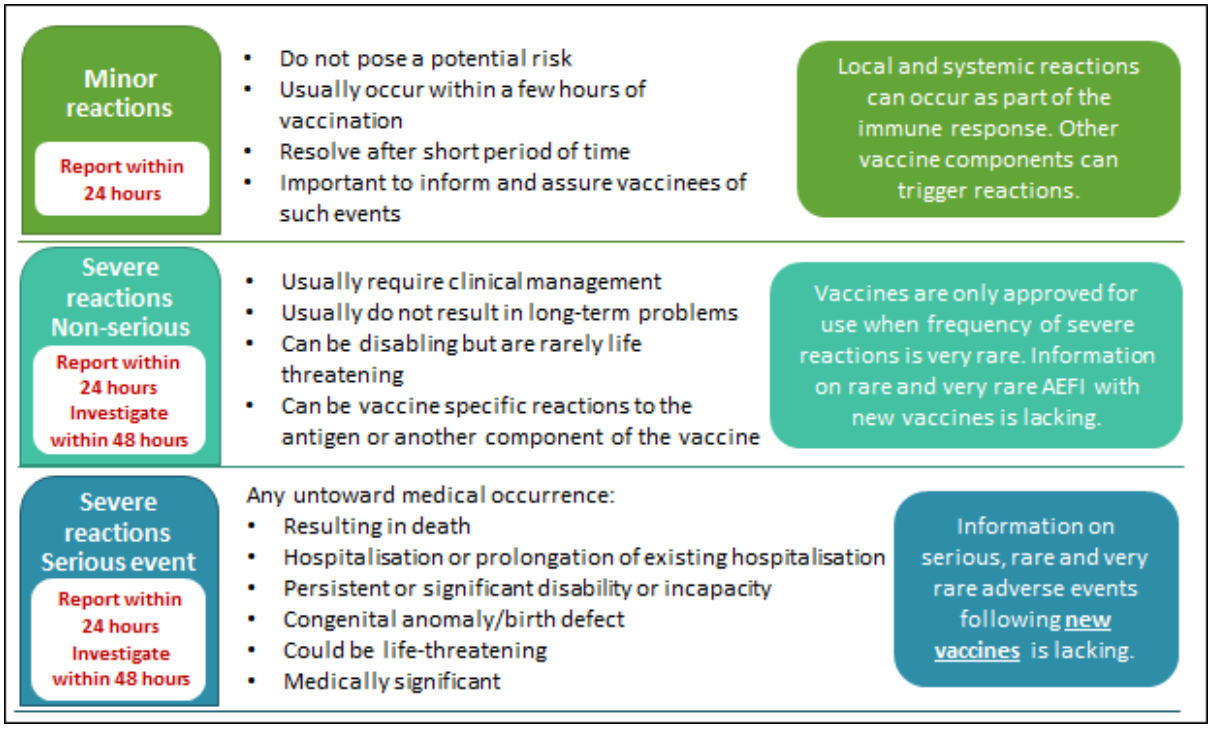
- The mass vaccination campaign report will include a detailed report on each AEFI, accompanied by all documentation including the standard case reporting form. A detailed investigation description of events must be included in the report and standard case investigation. Paper-based forms must be completed and submitted to NDOH: EPI (Marione.Schonfeldt@health.gov.za).

23.1. Roles and responsibilities of stakeholders in reporting AEFI

Stakeholder	Responsibility
Vaccine recipients'/vaccine recipients, parents, guardians, caregivers	Receive counselling at the vaccination site, from healthcare workers about expected AEFI and how to manage them. Manage minor adverse events as advised during counselling (e.g. correct positioning of the child when sleeping, increasing intake of fluids, sponging, breast feeding, antipyretics, etc.) at home Report any adverse event of concern, and seek medical treatment when required

Stakeholder	Responsibility
	Identify and notify severe unexpected events (e.g. very high fever, not responding to antipyretic) or other unusual events to the healthcare facility Report the AEFI on the Med Safety App, or email AEFI@health.gov.za if possible
Vaccinators and other healthcare workers/providers	Identify adverse events experienced by vaccine recipients Provide primary medical care for adverse events according to the standard treatment guidelines or refer specific health facility for management. Contact the clinician/ physician at the referral health facility e.g. tertiary hospital if any advice is required Report the event through the Med Safety App or on the paper-based case reporting form (CRF). All minor, severe/serious AEFI/AESI and cluster of events should be reported within 24 hours Notify the District Surveillance Officer (DSO) using the standard case reporting form (Annexure 1) or provide the Med Safety App generated SAHRPA-reference number for all AEFI reported Obtain and EPID number from the district / provincial office.
The district surveillance officer (DSO)	Provide EPID number for all AEFI reported. Submit the completed CRF from the health facility, district to the Provincial / District Surveillance Officer or District / Provincial EPI-CDC Manager within 48 hours. Review AEFI reported, and determine if case investigation is required based on the case definitions of serious, severe AEFI/AESI and cluster of AESI. In case of serious AEFI, the DSO is responsible to facilitate case investigation by the district investigation team. Case investigation should start within 48 hours after the AEFI was reported Add all cases to the district AEFI line-list

24. Timelines of reporting of AEFI



25. Vaccine Management

Districts should have a distribution plan for vaccines and related supplies.

- All Measles vaccines will be supplied in boxes of ten single dose vials.
- All vaccine stock will be clearly marked as **"Campaign Stock".**
- Vaccines must be stored between 2 - 8° C at all times.
- All campaign stock must be kept separate from routine stock, Use a separate stock card).
- All facilities should maintain accurate stock control.
- A measles vaccine audit must be conducted by each facility at the end of the campaign (stock received minus stock left over after the CAMPAIGN = stock used). This must be reported in the Facility campaign report.
- After the audit all remaining stock can be used as routine stock.
- Vaccine usage and vials remaining at the end of the measles campaign must be calculated per province/district/sub-district/facility.
- Districts should have a distribution plan for vaccines and related supplies.
- For additional child health services during the campaign, districts should also ensure distribution of other supplies e.g., Vitamin A, deworming tablets and syrup.

- The stock visibility system will be utilised to identify facilities with vaccine stock-outs, and a contact list of the responsible pharmacist per sub-district should be provided to facilitate prompt action to address any vaccine stock-outs identified.
- Adequate stock levels should be maintained and compliance with effective vaccine management principles.

26. Emergency Trays

- All health care facilities/ posts/ Outreach administering immunisation and school health teams must have an emergency tray available at all times complying with the minimum standards as indicated below. An emergency tray should have a checklist of all the required emergency drugs and supplies, and it should be checked daily by a vaccinator.
- All vaccination posts should have a basic AEFI management kit and reporting forms.

26.1. Checklist for emergency tray:

- 2 ampoules of Adrenalin injection (1:1000) solution
- 1 vial of hydrocortisone (100 mg)
- 2 sets of disposable syringes with 0.01 ml graduations and 26 G IM needles
- 2 sets of disposable syringes (5 ml) and 24/ 26 G IM needles
- 2 scalp vein sets
- IV fluids (normal saline)
- IV fluids (5% dextrose)
- IV drip set
- AEFI reporting form.
- Drug dosage tables for adrenaline and for hydrocortisone
- Adhesive dressing

At hospital setting, oxygen support and airway intubation facilities are expected to be available.

27. Emergency procedure in the case of anaphylaxis

Anaphylaxis is a very severe reaction, which may occur after the administration of any immunisation. The patient collapses with signs of shock and breathing problems.
Follow the steps described immediately:

1. Call for help and assist the patient immediately.
2. Check breathing and heartbeat:
   - If the patient is not breathing, secure the airway and assist breathing (mouth-to-mouth or ambubag)
   - If there is no heartbeat do Cardiopulmonary Resuscitation (CPR)
   - If the child has shock or difficulty breathing, give oxygen (40%) by facemask at a flow rate of 15L/min.
3. Administer epinephrine (adrenaline) 1:1000. Give the following dose:
   - 0 – 3 years: 0.1ml IM
   - > 3 – 5 years: 0.2ml IM
   - Can be repeated every 5 minutes, if necessary (maximum dose 0.5ml).
4. Administer hydrocortisone in the following doses:

Age	Dose and Route of administration
< 3 years	50 mg slow IV or IM
4 – 5 years	75mg slow IV or IM

5. If signs of shock are present (low BP and/or fast, weak pulse) also give 20ml normal saline IV.
6. Transport the patient immediately to the nearest fixed facility.

28. Data Management, Monitoring & Evaluation

- **Please note that all services rendered during the measles campaign should be recorded in the Road to Health Booklet.**
- **In cases where a care giver presents with no RTHB; either forgotten at home or lost; the measles campaign services should still be rendered.**
- **In cases of a lost RtHB, the services are recorded in a newly issued RtHB.**

- One of the strategic priority goals of the global Immunisation Agenda 2030 (IA2030) is to introduce and scale up new and underused technologies, services and practices. In responding to the IA2030 call to scale up use of tools that will support the provinces to achieve the high-quality data, three types of data collection tools will be utilised, namely, DHIS2, ODK and Paper-based tools. The digital

technologies are highly recommended during this campaign to accelerate the sharing, analysis and use of data to improve campaign quality by helping implementers to review progress against targets; identify issues and gaps; track supplies, human resources and vaccine sessions; and make prompt decisions about corrective actions. Paper-based forms must be completed and submitted to NDOH: EPI (Koko.Molema@health.gov.za).

28.1 DHIS2 dashboards for real-time monitoring (Not applicable for the Western Cape. Please revert to Circular 13/2023)

- For management of data, the DHIS2 App will be used for real-time collection and transmission of data from immunisation sites across the country, as well as real-time tools to monitor performance of key indicators at the national and district levels. The DHIS2 dashboard will allow national, provincial and district levels to drill down into the data visualisations in real time. The key indicators selected for real time monitoring will include vaccination coverage and logistics monitoring.

- HISP will provide technical support in terms of setting up DHIS2 App. implementation, which will transmit data captured in the field by vaccination teams to a central server. The custom DHIS2 Dashboard App will ensure transmission of real-time data from immunisation sites to the national and provincial offices where the data will be used to inform real-time decision making such as a timely decision to extend the campaign duration **at least not more than a week.** At the NDOH, a smart display TV donated by WHO will be set up to monitor campaign progress.

- Training will be done, and training materials with Job Aids will be made available in November 2022.

29. Open Data Kit (ODK) app for supervision

- For campaign supervisory visits, real-time data will be collected using ODK app. The WHO IST through SA country office will provide technical support in terms of setting up an ODK implementation, which will transmit data captured in the field by vaccination teams to a central server.

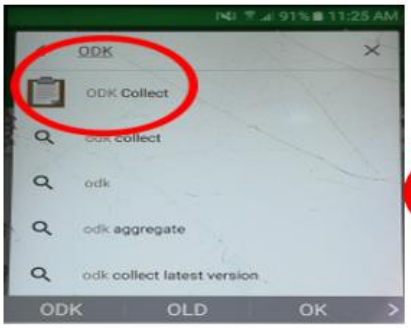
29.1. Instructions for Installing ODK *(Paper-based tools may be used in the Western Cape.)*

STEP 1:

- **Ensure availability of internet connection.**
- **From the home screen select the icon shown to view applications on the phone.**
- **On the resulting screen select "Play Store"**

This Maybe different in some Androids depending on the version but whatsoever look for the play store Icon and select it

STEP 2:



- Once the play store screen is displayed,
  - click on the search icon and type **"ODK Collect".**

➔ **ODK Collect** will appear.

- Double click on the icon

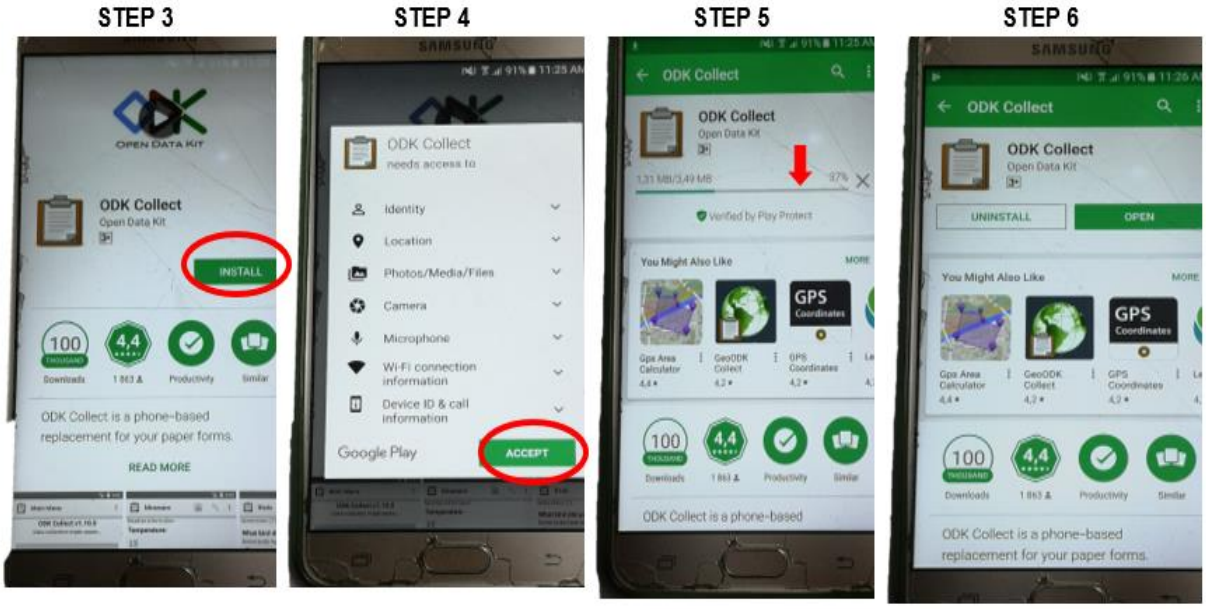
➔ The screen with details of the application will be displayed.

- Click on **install.**

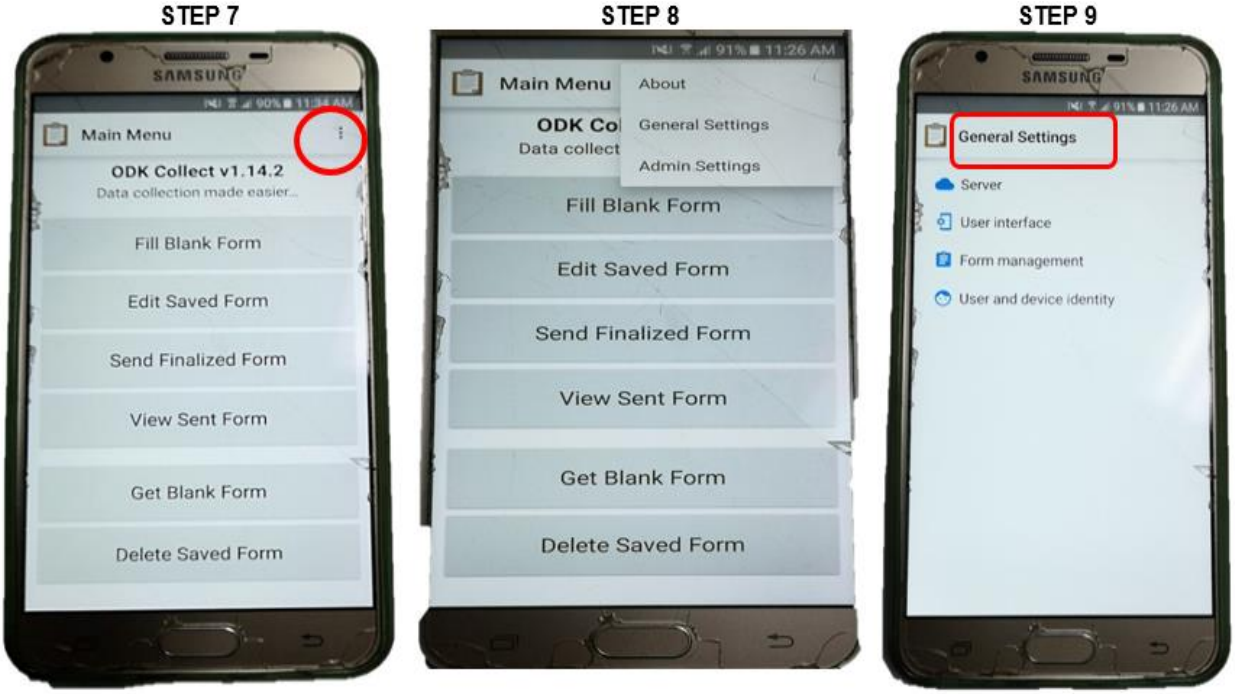
- **If you are asked for a Google account, DON'T create one, use the following existing one:**

Account: sierramdd@gmail.com
Password: sierra.948

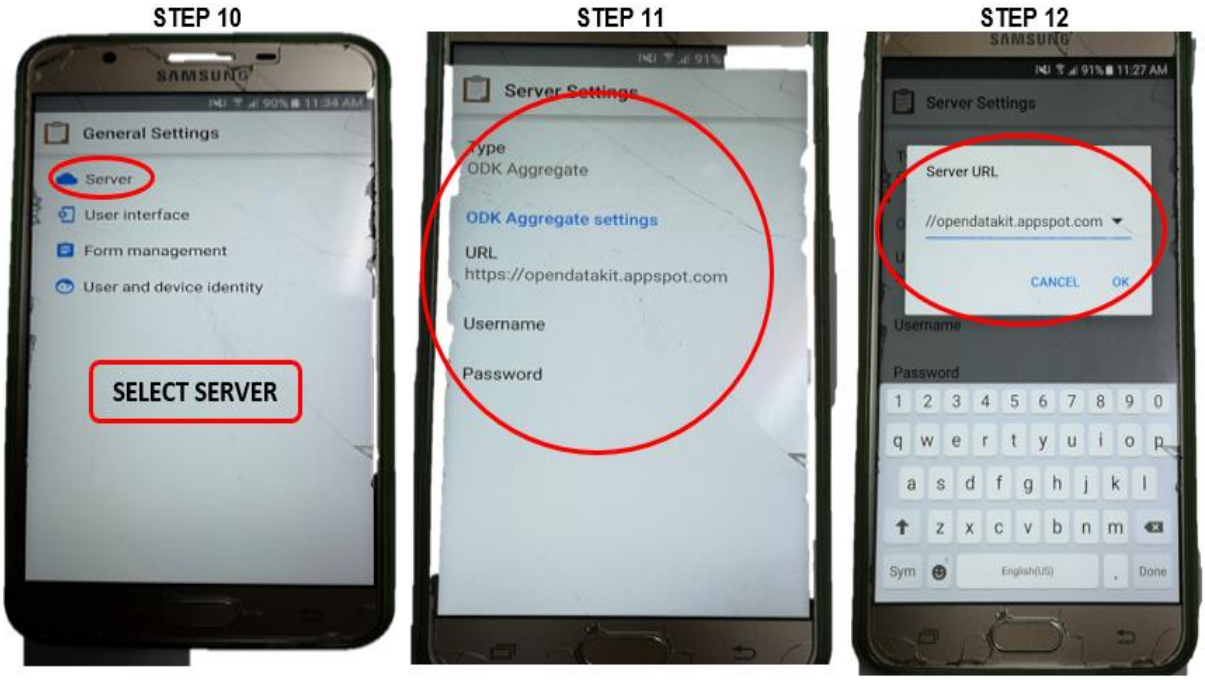
STEPS: 3–6



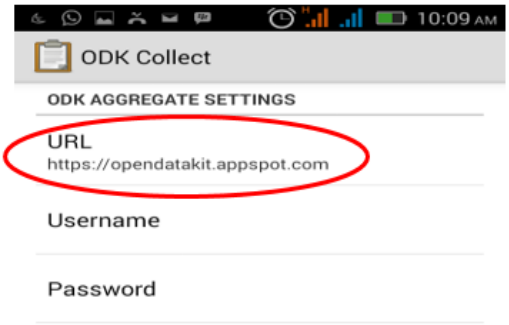
STEPS: 7-9



STEPS: 10-12



STEP: 13a



select **"URL"**

– **Change the URL to**
http://esurv.afro.who.int/whosouthafrica

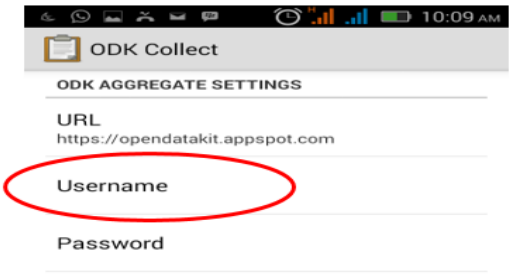
– then enter the following details

– **Username: southafricamdd**

– **Password: S0uth@fric@123**

- **Enter your own country's credential!**

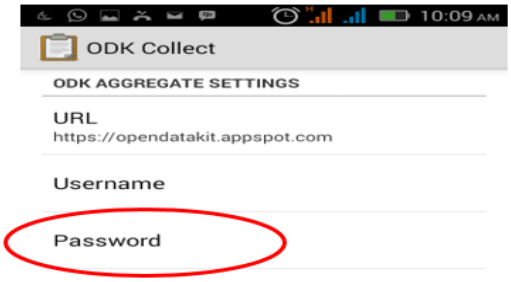
STEP: 13b



select **"URL"**

- **Change the URL to**
  http://esurv.afro.who.int/whosouthafrica
- then enter the following details
- **Username: southafricamdd**
- **Password: S0uth@fric@123**
- **Enter your own country's credential!**

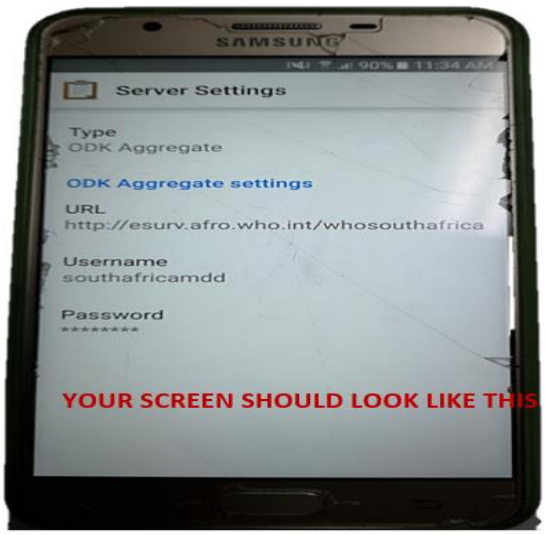
STEP:13c



select **"URL"**

- **Change the URL to**
  http://esurv.afro.who.int/whosouthafrica
- then enter the following details
- **Username: southafricamdd**
- **Password: S0uth@fric@123**
- **Enter your own country's credential!**

STEP:13d



URL: http://esurv.afro.who.int/whosouthafrica

Username: southafricamdd

Password: S0uth@fric@123

30. Paper-based data tools

30.1. Use of tally sheets

- The DATE of the measles vaccination campaign, facility name, district and sub-district names must be completed on EACH Tally Sheet
- The person completing the tally sheet should write their name and cell phone number.
- Tallying should only be done after the intervention/service has been offered. There should be no pre-tallying.
- When tallying mark off a numerical square in sequential order for each child vaccinated on the tally sheet.
- Use a new tally sheet each day.
- Tally sheets will be printed as duplicated pages. One copy of the completed tally sheet will remain in the facility and one copy will be submitted attached to the daily summary sheet.
- All data from the tally sheets belonging to that facility must be transferred onto the Daily Summary Sheet and the tally sheets attached to the Daily Summary Sheet.
- Each service must be tallied in the correct tally sheet.
- For the 2023 integrated measles vaccination campaign; there are 3 tally sheets for **3 interventions/services as below:**
  - Measles vaccination
  - Mebendazole tablets for deworming
  - Vitamin A supplementation
- Ensure that all posts have all the 3 different types of tally sheets for the campaign.

30.2. Daily summary sheet

- All data from the tally sheets belonging to that facility must be transferred onto the Daily Summary Sheet and the tally sheets attached to the Daily Summary Sheet.
- Daily Summary Sheets must be sent to the next level daily once they have been verified and signed by the clinic supervisor or designee.
- The EPI coordinators at each level must report the daily figures to the next level daily.
- The provincial EPI, Child Health and Nutrition Managers must report the provincial figures to EPI (SA) daily to (Ms Koko Molema @ Koko.Molema@health.gov.za).

NB: HPV vaccination campaign data is still collected through the paper-based system (daily registers and summary sheets) and managed by provincial HPV vaccination Coordinators

31. Capturing data onto DHIS

31.1. Facility Manager/coordinator

- Verifies and signs tally and daily summary sheets.

- Capture all data from outreach posts linked to fixed facility into the DHIS2 App.
- The carbon copy of the daily summary sheet is sent together with tally sheets to the sub/districts or districts.

31.2. Sub-district/District Information Officer

- Verifies the data on tally and summary sheet.
- Captures data into the web DHIS daily.
- In case the sub-district/district does not have internet connection, use E tick register (Offline system) to capture data and save the captured data into the USB/external hard drive.
- Identify a nearest institution with internet connection e.g. Hospital to import data from the E tick registers into the web DHIS daily.

Data Flow and Time Frames

Health Facility

Verify and forward tally and daily summary sheets/ data to Sub district by 10h00 daily.

SUB-DISTRICT/ LSA/Municipality/District/Metro

Keep register of all incoming summary sheets.
Verify and capture data into the webDHIS or E tick register daily.
If Data is captured into the E tick register, it should be imported into the web DHIS on the same day.
Officials from the National should have access into the provincial webDHIS to monitor the daily progress of the campaign.

32. National

- HISP to import data from provincial web DHIS into the National web DHIS.

33. Measles and HPV vaccination campaign supervision

- Districts should ensure that Supervisors are identified and assigned to monitor vaccination campaign teams. They should be identified from the most experienced health workers within the district management team. The district supervisors must conduct daily supervisory visits during the campaign.

  - The Supervisor should use the Supervisor's Intra-Campaign Evaluation Checklist in the ODK App

- Clinic coordinators should ensure that all data from DHIS2 app is complete and synchronised daily.
- Clinic coordinators should ensure that Daily Tally & Summary Sheets and related vaccination forms are correctly completed each day.
- Each clinic should carry buffer stocks of vaccines, except for HPV vaccine which is only available for schools, Vitamin A, Deworming tablets and other supplies to replenish teams that have run out of stock and supplies (vaccines and ancillaries, tally sheets, AEFI, CRFs & CIFs, etc.).
- Each **Supervisor** should supervise his/her designated areas daily and ensure that:
    - Measles vaccine is correctly reconstituted and administered.
    - Only one vaccine vial is opened at a time.
    - Injection safety practices are observed.
    - VVM is good and vaccines are within the expiry date.
    - Vitamin A and Deworming tablets have not expired.
    - Teams have adequate quantities of vaccines, Vitamin A, Mebendazole tablets, and other supplies.
    - All vaccine vials when not in use must be kept in the vaccine carrier with cold packs.
    - Teams arrive at vaccination sites at scheduled times and do not leave before all children have been vaccinated. If moving from point to point, ensure that the next point is notified if team will be late due to heavy workload at previous point.
- The Supervisor should use the data from DHIS2 App and paper-based tally sheets to review progress against targets; identify issues and gaps; track supplies, human resources, and vaccine sessions; and make prompt decisions about corrective actions.
- Short meetings should be conducted with all the supervisors daily in the afternoons or in the morning before departure.

34. Pre-, Intra-, & Post Campaign Evaluation

- There are annexures attached for campaign activities which must be used to conduct the pre, intra and post campaign evaluation activities in all districts.
    - Pre – campaign: use ODK for the pre-campaign check list and “social mobilisation surveys”
    - Intra -campaign: use ODK for the intra campaign check list and “intra campaign rapid convenience surveys”
    - Post campaign: use the ODK post campaign check list and “post campaign rapid convenience surveys”.

35. Independent campaign monitoring

The National Department of Health requests that each province set up a team of health professionals, possibly from the Medical Universities, Schools of Public Health or other health professionals not directly involved in EPI, to act as independent monitors for the province during the Campaign. Monitoring tools have been developed for this purpose and include all spheres of the Campaign namely pre-, intra-, and post-campaign evaluation. The pre campaign evaluation is an important tool used to assess if social mobilisation activities have reached all population areas/groups. The intra campaign evaluation conducts direct observation at immunisation posts and conducts Rapid Convenience Surveys to identify if there are any pockets of unimmunised children remaining after the Campaign and assist in identifying areas for mop-up activities. The post campaign evaluation highlights lessons learnt and identified strengths and weaknesses in the Campaign.

Each team should be trained in the use of the independent monitoring tools. The independent monitoring team will assist the province and help with evaluation and monitoring of the Campaign to ensure a good quality Campaign.

Loadshedding plans?

- If possible, have all vaccine fridges connected to a generator support and stored in long holdover fridges.
- If possible, install smart temperature monitoring devices in all fridges and log tags in cold boxes when transporting.
- Have a contingency plan: a storage site to relocate vaccines in case of longer loadshedding.
- Use the freezer compartment to freeze water bottles. Place them inside the fridge for weekend loadshedding expectations.

36. Annexes

Annexure 1. Consent form

Annexure 2. Referral Slip

Annexure 3. Measles vaccine tally sheet

Annexure 4. Mebendazole tablets tally sheet

Annexure 5. Vitamin A tally sheet

Annexure 6. Daily Summary Sheet

Annexure 7. ODK Pre-campaign readiness assessment checklist

Annexure 8. ODK Intra-campaign readiness assessment checklist

Annexure 9. Vaccine Usage and Wastage Reporting Form

Annexure 10. AEFI Case Reporting Form

Annexure 11. AEFI Case Investigation Form