Refresher Training for Frontline Health Workers in Expanded Program of Immunization (EPI)

Module 5

Monitoring Immunization Coverage, Drop-out and Quality of Service

January 2005

Addis Ababa, Ethiopia

A collaborative in-service training jointly developed by the SNNPR, Oromiya and Amhara Regional Health Bureaus and the ESHE Project

ESHE
ESSENTIAL SERVICES FOR HEALTH IN ETHIOPIA

Amhara Region

Oromia Region

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The Refresher Training Modules Were Principally Adapted From the Following Sources:

- WHO Immunization in Practice
- WHO Mid-Level Managers Training
- WHO module on Increasing Immunization Coverage at Health Facility Level
- MOH and WHO/Ethiopia, "Improving routine immunization coverage in Ethiopia through Reaching Every District (RED) approach."

Draft set of five modules developed by FMOH/Nigeria and BASICS II

Essential Services for Health in Ethiopia is implemented by John Snow, Inc. in collaboration with Abt Associates Inc., the Academy for Educational Development, and Initiatives, Inc.

Financial support for this module was provided by the US Agency for International Development, contract number 663-C-00-04-00403-00. The views expressed in this document do not necessarily reflect those of USAID.

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Acronyms

AFP	Acute Flaccid Paralysis
BCG	Bacillus of Calmette and Guerin (tuberculosis vaccine)
DPT	Diphtheria-pertussis-tetanus vaccine
EPI	Expanded Program on Immunization
IUDS	Intrauterine Devices
OPV	Oral polio vaccine
TT	Tetanus toxoid
VVM	Vaccine vial monitor

About Module 5

This module describes the process of examining immunization data, procedures and practices linked to implementation of program activities. The information is used to direct the program in planning, measuring progress, identifying areas needing specific interventions and, revision of plan if needed.

1. Monitoring Immunization Program

1.1 Definition

Monitoring is the process of continuous observation and data gathering with the aim of comparing what you have achieved with your targets.

Monitoring Immunization Program Entails:

- ✓ Use of quality data to improve the planning and management
- ✓ Proper use of EPI Monitoring tools: For continuous self monitoring at health facility level (e.g. Wall charts)
- ✓ Use of Indicators: coverage, completeness, timeliness
- ✓ Feedback

The most important function to monitor is the trend in immunization coverage and drop-out rates at local level. These should be compared with previous period and the planned objective. Depending on the purpose, monitoring can be daily, weekly, monthly or quarterly, but it must be regular.

1.2 Monitoring Tools

Important monitoring tools used in immunization programs include:

1. Maps – population distribution in relation to the location of health facilities.

2. Child health card

- a unique identification number
- name of infant
- infant's birth date
- infant's sex
- name and address of mother
- date of each vaccination by dose and vitamin A supplementation
- infant protection at birth from neonatal tetanus (PAB)
- due date for next immunization
- growth monitoring chart (optional).

3. Immunization register (Annex I). You must register infants and pregnant women as soon as they arrive at the health facility or outreach site. The immunization register helps health workers keep track of the immunization services they offer to each infant and to pregnant women.

4. Immunization tally sheets (Annex II). Tally sheets are forms on which health workers make a mark every time they administer a dose of vaccine. These are used as basis for monitoring and reporting. Use a new tally sheet for each session. The same tally sheet can be used to mark both vaccines given to infants as well as vaccines given to pregnant women (Annex III).

5. Monthly immunization monitoring chart (Annex - III)

1.3 Immunization Monitoring Chart

One of the best monitoring tools for immunization coverage is the immunization monitoring chart, which shows the monthly progress health workers are making in raising immunization coverage in the health centre catchment area. This chart enables health workers to compare the number of people actually immunized each month with the coverage targets. Each vaccine, even each dose of the same vaccine can have a monitoring chart. In order to be viewer – friendly, not more than two vaccine components should be located in one chart. This will facilitate following progress simultaneously for two components as well as to calculate drop-out rates between them.

The health facility is the typical location to use the chart, but it can also be used at higher levels (district, province, central). Office charts and other monitoring tools are useful in monitoring coverage and drop-out rate. They should be regularly updated when new data are received from health facilities to identify facilities with problems, give more support to those health facilities that do not perform well and acknowledge and commend good performance.

2. Managing Immunization Problems

The process of managing problems involves:

- Analyzing problems
- Identifying causes of problems
- Identifying possible solutions

2.1 Analysis of Problems

For immunization to be effective in preventing cases and deaths, every child should be fully immunized.

There are two main ways to estimate whether implementation of the immunization services have actually or at least have the potential to reduce the target EPI disease(s):

- Measure immunization coverage for each vaccine:
- Measure drop-out rates:

2.2 How to Measure Immunization Coverage

Immunization coverage is measured by comparing the number of doses given to the number of eligible surviving infants.

Percentage coverage with the vaccine or vitamin A	=	Number of infants under one year of age receiving all required doses for selected vaccine or vitamin A during the last 12 months / Target population of infants under one year of age or live births	X 100

Note: *If the number of immunized children is greater than the target population, the reason should be identified (e.g. inadequate target population data, number of immunized children including other age groups than the target one, or including children from other areas.).*

After determining immunization coverage, you need to interpret the data in relation to planned targets.

- Compare immunization coverage with the objectives *(i.e set targets)*
- Compare coverage with the figures of the previous period *(i.e. trends)*
- Compare coverage achievements between zones, districts health facility catchment areas
- Determine accessibility to the health facility (refer to DPT1 coverage)
- Determine utilization of health service (refer to DPT3 coverage)
- Examine difference between coverage levels of various vaccines given at the same time.

Immunization coverage and drop out indicators

Indicator	What it may indicate	Limitations
DPT1 coverage	Availability of, access to, and initial use of immunization services by children.	Measures only the first in a three-dose series. BCG, although the first vaccination in the schedule, is not an effective indicator where births take place at home and no BCG is given. When BCG is given to babies born in hospitals, it may be recorded in a different information system, if at all.
DPT3 coverage	Continuity of use by parents, client satisfaction with services, and capability of the system to deliver a series of vaccinations.	Shows only completion of DPT series and not other antigens.
Measles coverage	Protection against a disease of major public health importance.	Does not indicate the capability of the system to deliver a series of vaccines. Supplementary doses may be confused with routine doses.
DPT1 to DPT3 (Difference in the number of children who receive DPT1 and the number who receive DPT3, expressed as a rate)	Quality of service as perceived by parents and the quality of communication between parents and health workers — this is the classic drop-out indicator.	Does not stand on its own; must be interpreted in light of actual coverage levels. Does not give a complete picture of drop-outs that may be occurring between other antigens.
TT1 coverage	Availability of, access to, and use of immunization services by pregnant women.	Measures only the first dose in a multi-dose series.
TT2+ TT2, TT3, TT4, and/or TT5 coverage)	Continuity of use, client satisfaction, and capability of the system to deliver a series of vaccinations to women.	The series of five TT doses is given at different intervals over the course of many years. Once a woman has received five doses, she should no longer be counted in the denominator as a member of the target population.
Fully immunized child (FIC)	Capability of the system to provide all vaccines in the childhood schedule at the appropriate age and the appropriate interval between doses in the first year of life; also measures public demand and perceived quality of services.	Generally not available from routine service statistics. Information can usually be derived from population -based surveys analyzed by WinCOSAS or other software. Absence of vaccination cards limits the reliability of this indicator. The definition of FIC may vary among countries.

Examples of Using Coverage Data to Improve Vaccination Services

Coverage data	Issue	Possible reasons	Suggested Remedy
Example 1: BCG 80% DPT1 60% DPT3 55% Measles 55%	Why the decrease between BCG and DPT1 vaccinations?	Missed opportunities to give vaccination card and information at place of birth	When mothers give birth in maternity centers, give their babies BCG vaccine and: - A vaccination card for the baby - Information on where and when to bring the baby for other vaccinations - Encouragement to get the baby immunized again as soon as he or she reaches 6 weeks of age
Example 2: BCG 80% DPT1 75% DPT3 70% Measles 45%	Why the decrease between DPT3 and measles?	The long interval between vaccination with DPT3 at 14 weeks and measles at nine months	Inform parents about preventing measles by means of vaccination. Remind parents when and where to bring the child in for measles vaccine.
Example 3: BCG 70% DPT1 70% DPT3 40% Measles 60%	Why is measles coverage higher than DPT3?	Difficult and/or infrequent access to vaccinations Health workers may be (incorrectly) re-starting DPT series after long intervals between doses.	Remind health workers that if a child has reached nine months of age without completing DPT vaccinations, a DPT vaccination can be given at the same time as measles vaccine. After DPT1 vaccination, remind parents that three doses are needed and when to bring child for DPT2 and DPT3.

"Funny Numbers" Exercise (with some possible answers)

Example 1: Coverage over 100%?

- *Possible answer*: For 6 months in a row, one health center recorded immunization coverage that exceeded expectations. Upon investigation, health workers realized that clients were coming to their health center from another catchment area where vaccine shortages were common. These individuals had not been in the denominator used to calculate coverage.
- *Possible answer*: Health workers included in their routine reports children over 12 months of age in calculating coverage. This inflated the numerator for calculating coverage, and since the denominator included only children under 12 months of age, the health facility's coverage appeared to exceed 100%.

Example 2: Higher DPT3 than DPT1 coverage?

- *Possible answer*: During a catch-up campaign, health workers classified all DPT vaccinations as DPT3 without checking whether individuals had received DPT1 or DPT2.

2.3 How to Measure Drop-out Rates

The drop-out rate is a comparison of number of children who start the immunization schedule and the number who complete it**.**

i) DPT1 to DPT3 drop–out rate:

$$\text{Formula: } \frac{\text{DPT1} - \text{DPT3}}{\text{DPT1}} \times 100 = \text{DPT1–DPT3 drop out rate (\%)}$$

ii) DPT1 to Measles drop –out rate:

$$\text{Formula: } \frac{\text{DPT1} - \text{measles}}{\text{DPT1}} \times 100 = \text{DPT1–measles drop out rate (\%)}$$

Also, calculate the annual number of un-immunized children that have not received DPT3, measles and any other vaccine in your health centre or district catchment area.

Target population – immunized children in target age group = Un-immunized children

DPT1 to DPT3/measles drop out rate is an indicator that is used internationally to evaluate the performance of immunization services. It measures the rate at which children who started the vaccination with DPT1 failing to complete the schedule. A drop –out rate of more than 10% entails that the particular health facility/centre has a utilization problem.

Some Local Causes of Dropouts

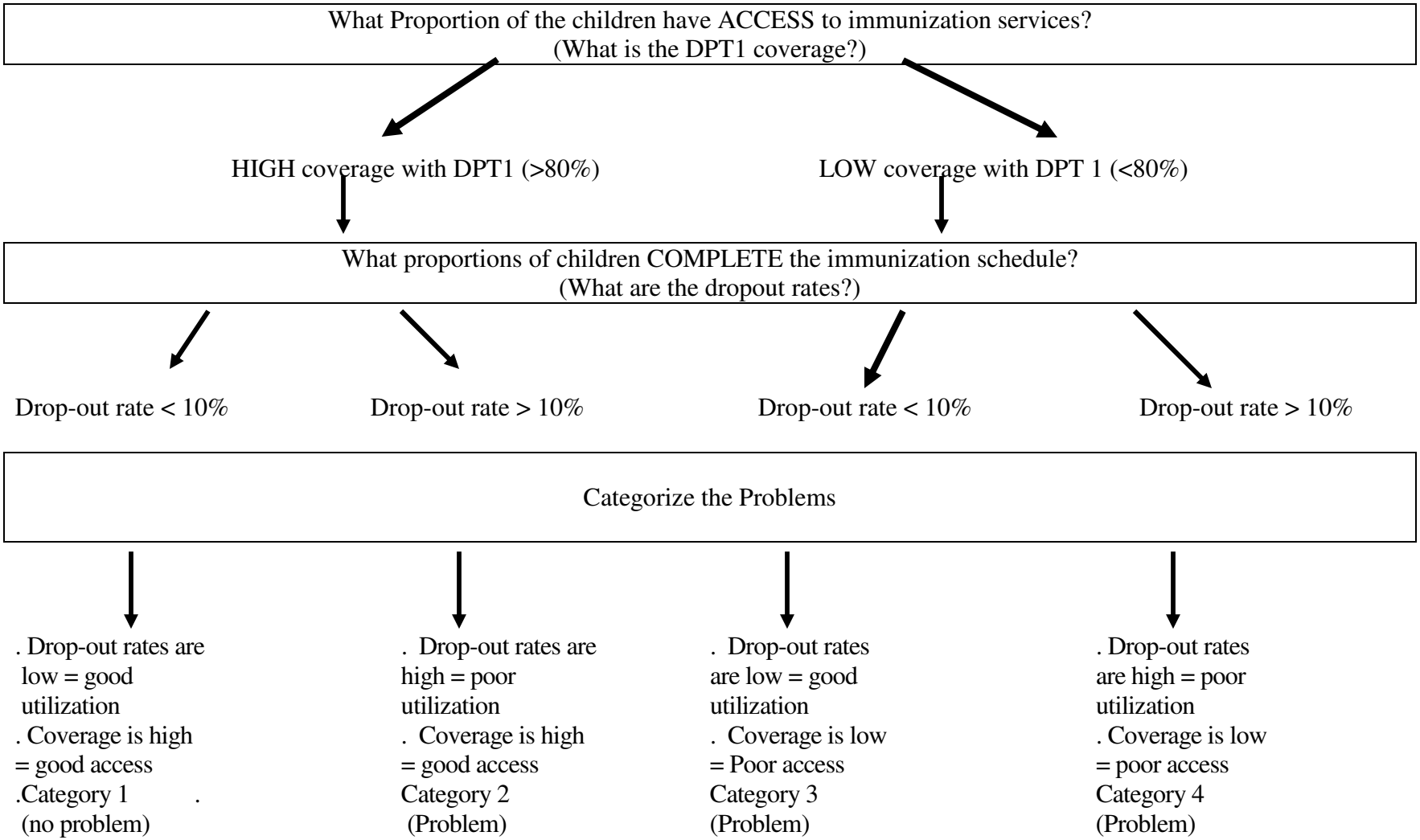
Service delivery

- Outreach sessions infrequent
- Vaccine shortage &/or Cold Chain breakdown
- Health staff perceived as "unfriendly"
- Improper contraindication practices
- Missed opportunities

Community

- Session times conflict with farming/family duties
- No active follow up of defaulters
- Community not informed of outreach dates

2.4 Analysis of Problem of Access and Dropouts



2.5 Determine Whether Access or Utilization Problem (see Annex- IV)

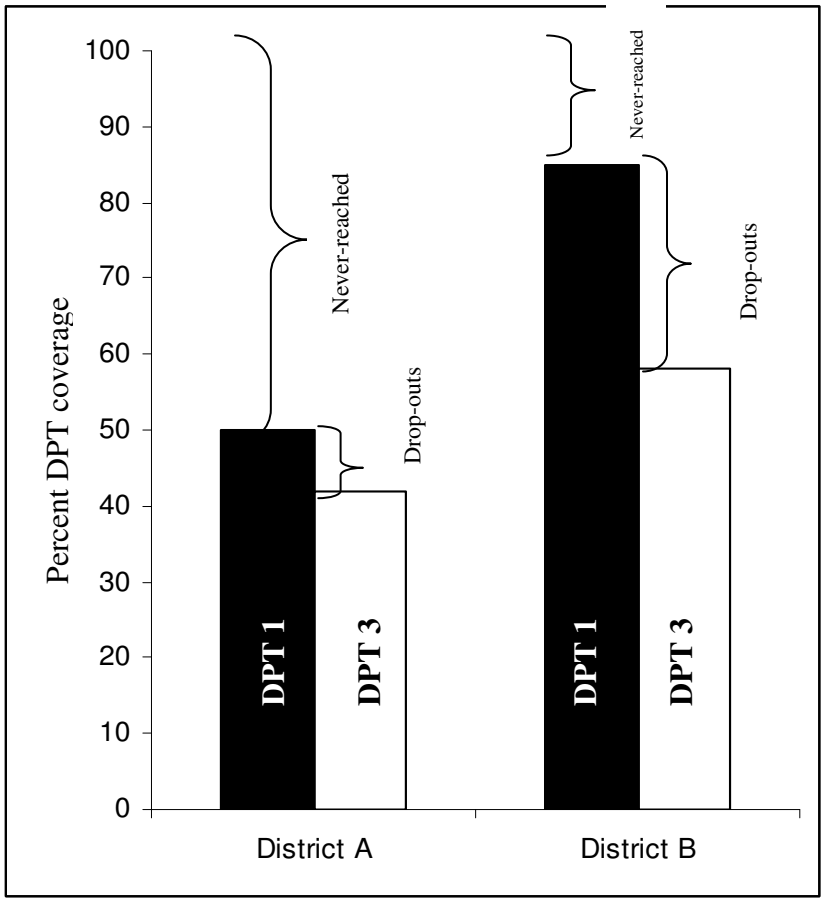
Use results from programme assessment/situation analysis to assess reasons for low coverage/high drop out rate. This should form the basis for micro planning, identification and prioritization of problems.

Identify and relate factors to causes of current coverage levels taking into consideration problems of access and utilization.

Example of Problem Analysis

Problems observed in a district or health facility	**Diagnosing a problem**
1. High DPT1 coverage and low drop-out rate	No problem
2. High DPT1 coverage and high drop-out rate	Utilization problem
3. Low DPT1 coverage and low drop-out rate	Access problem
4. Low DPT1 coverage and high drop-out rate	Access and utilization problem

Determine Whether Never-Reached or Drop-outs Problem



Never reached = 100% minus DPT1 % coverage

$$\text{Drop-out} = \frac{\text{DPT1 coverage} - \text{DPT 3 coverage}}{\text{DPT 1 coverage}} \times 100$$

District A. 50% of children have access to immunization services using DPT1 coverage as an indicator. 42% complete the three-dose series of DPT. The drop-out rate therefore is 16%:

$$\left(\frac{50\% - 42\%}{50\%} \right) \times 100 = 16\%$$

In District A, planners should give priority to raising DPT1 coverage by reaching the 50% of children who have never been reached. Reducing drop-outs would, at best, result only in a gain in DPT3 coverage from 42 to 50%.

District B. 85% of children have received DPT1. 58% complete the three-dose DPT series. The drop-out rate is 32%:

$$\left(\frac{85\% - 58\%}{85\%} \right) \times 100 = 32\%$$

In District B, reaching the last 15% of the population that has never been reached is likely to be labor-intensive and expensive. On the other hand, following up on dropouts and persuading them to complete the series could raise coverage of DPT3 from 58% to 85%. Unless additional information indicates otherwise, District B should give priority to reducing drop-outs.

2.6 Determine Causes and Solutions (see Annex IV)

Identify problems and root causes of problems in relation to six main headings:

1. **Supply:** quantity and quality of vaccines, equipment, etc
2. **Staffing:** quantity and quality of personnel - adequate levels, training, etc
3. **Service delivery:** quantity and quality - regularity of vaccination sessions, demand in the community, etc.
4. **Community Participation**: number of attendants, defaulters, etc
5. **Data collection and Reporting** – Completeness, Timeliness, etc
6. **Supervision, Recording & Reporting, Monitoring & Evaluation**: Frequency of supervision & report, usage of monitoring charts, etc

For each problem identified, there are many possible solutions:

- Improved communication with the community
- In-service -training
- Supportive Supervision
- Mobilization of additional resources
- Apply innovative immunization strategies e.g. sustainable outreach strategies, local immunization day's, focus group discussion, etc.
- Partnership with private and other sectors.

3. Supervision to Help Health Staff Solve Problems

Health facilities should receive supportive supervisions from District/Zonal/Regional staff with clear supervision goals to help health staff solve problems. It is useful to have supervision tools (See Annex - V). On site training could also be provided to:

- Help districts/health centres produce work plans
- Use of monitoring wall-chart
- Making a map with target population
- Vaccine & injection equipment forecasting and ordering
- Appropriate use of syringes and safe disposal of used immunization equipment

4. Immunization summary Reports

The immunization data collected needs to be consolidated into a summary form, either manually or electronically, for transmission from the health facility to the district level. The district compiles data for use by health facilities and transmission to the next level, and eventually to central level. At each level the data should be analyzed and used to improve the program. The format of the summary report should be defined at district/Regional level and should be standard for all health facilities.

Preparing Good Reports

Health workers should ensure that the reports prepared are:

- **Complete**: All the sections of the reports have been completed; no parts have been left blank and all reports due from reporting sites have been received.
- **Timely**: When reports are sent and received on time, the possibility of a prompt and effective response is greater.
- **Accurate**: Before sending the reports, double-check totals and all calculations. Make sure that the reported figures correspond to the actual figures.

The district, province, national levels should keep track of the completeness and timeliness of reporting by the more peripheral level, and remind those levels of missing or late reports.

Summary report from the health facility should include: (see Annex - V)

1. Vaccinations given to infants and women and vitamin A. Data collected on the tally sheets needs to be consolidated into a summary form.

2. Vaccine-preventable diseases in your area. State the number of cases of each vaccine-preventable disease and the immunization status of each case. Even if there are no cases of a disease during the reporting period, you should still provide a 'zero' report in the format.

3. Adverse reactions following immunization. If there have been any adverse reactions during the month, details may be provided to the next level:

- those that are **life threatening** , resulted in **hospitalization** , **disability** (or have the potential to result in disability) or those that result in **death**.

4. Vaccine usage and wastage patterns. The usage and wastage of vaccine will vary greatly from one session to another. However it is useful to monitor wastage and usage patterns regularly at all immunization points to improve supply and avoid stockouts. This can be done by recording vaccine vial start and end balances, and vials received each month**.**

5. Any specific problems encountered during the reporting period (e.g. stock-outs, transportation problems, cold chain failure etc.)

This is an opportunity to report supply problems and record supervisory visits.

(Example)

ANNEX I

EPI REGISTRATION BOOK

Reg. No	Date	Full Name (Including Grandfather)	Sex	Date of Birth	Address		Card* no	Date Immunization**					Fully Vaccinated (✓)	GM	Remark
					Woreda	Kebele/Town		BCG Polio 0	DPT1 Polio 1	DPT2 Polio2	DPT3 Polio3	Measles			

* The card no. to be entered here concerns children who are referred from the sick-child room.

** Enter two dates in the cell for the two antigens.

Annex- II: TALLY SHEET (Example)

DATE STARTED_____

HEALTH INSTITUTION_____ REGION_____ DATE ENDED_____

VACCINATIONS

Type of vaccination	0-11 months (1 year)	Total	12 months & Over	Total
BCG				
Polio at Birth				
Polio 1				
Polio 2				
Polio 3				
DPT 1				
DPT 2				
DPT 3				
Measles				
Fully Vaccinated				
TT 1 (women 15-49)				
TT 2				
TT 3				
TT4				
TT5				

FAMILY PLANNING

Type of Contraception	First Visit	Total	Revisits	Total
Pills				
IUDS				
Condoms				
Depot Injection				
Others				
Total				

ANTENATALS

First Visit	Total	Revisits	Total

POSTNATALS

First Visit	Total	Revisits	Total

CDD ARI

Children <5	Total	ORT Given Total children < 5	Total

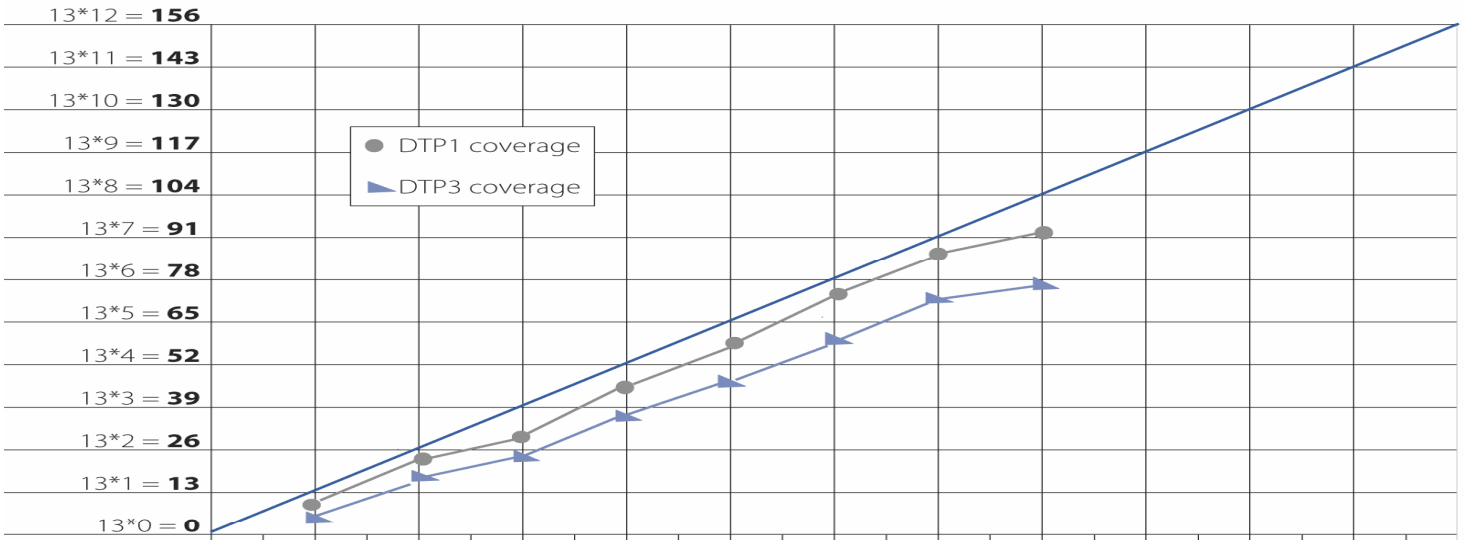
GROWTH MONITORING

Status (weight for age)	First Visit	Revisits
Over 80%		
70-80%		
60-70%		
60%		
TOTAL		

***ATTENDANTS ALL DISEASES < 3**

TOTAL

ANNEX III Worked example of a monitoring chart for DPT1 and DPT3



FILL IN AT THE END OF EACH MONTH	JAN	CUM. TOT.	FEB	CUM. TOT.	MAR	CUM. TOT.	APR	CUM. TOT.	MAY	CUM. TOT.	JUNE	CUM. TOT.	JULY	CUM. TOT.	AUG	CUM. TOT.	SEPT	CUM. TOT.	OCT	CUM. TOT.	NOV	CUM. TOT.	DEC	CUM. TOT.
TOTAL IMMUNIZED DTP1	10	10	12	22	7	29	12	41	14	55	15	70	14	84	7	91								
TOTAL IMMUNIZED DTP3	8	8	9	17	8	25	10	35	11	46	12	58	12	70	7	76								
DROP OUT NUMBER (DO) (DTP1 - DTP3)		2		5		4		6		9		12		14		15								
DROP OUT % (DO/DTP1) * 100		20		23		14		15		16		17		17		16								

Annex IV: Diagnosis/Planning Action

	CAUSES of problems	ACTION With existing resources	ACTION With extra resources
Supply quality			
Supply quantity			
Staffing quality			
Staffing quantity			
Service quality and demand			
Service quantity and demand			

EXAMPLE

Annex V. MONTHLY EPI PLUS VACCINATION REPORTING FORM (REVISED 2002) (FOR WOREDA HEALTH OFFICE LEVEL ONLY)

ZONE_____ WOREDA _____ MONTH _____ YEAR_____

No	Health Unit	Vaccination Site		VACCINATION AND VITAMIN A GIVEN TO UNDER ONE YEAR CHILDREN										
		Static	Out Reach	BCG	Measles	DPT 1	DPT 2	DPT 3	POLIO 0	POLIO 1	POLIO 2	POLIO 3	Fully Vaccinated	Vitamin A
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
	Total													
	Other age groups (12-24 months)													
	Grand Total													

Page 1

No	Health Unit	VACCINATION AND VITAMIN A GIVEN TO WOMEN													
		NON PREGNANT							PREGNANT						
		TT1	TT2	TT3	TT4	TT5	TT2+	Vitamin A	TT1	TT2	TT3	TT4	TT5	TT2+	Vitamin A*
	Total														

* Only if 10,000iu Vitamin A capsule is available

HEALTH EDUCATION ON EPI/VITAMIN A

No	SUBJECT	No of Session	No of Attendants		
			M	F	Total
1					
2					
3					
4					
5					
6					
	Total				

TRAINING/SEMINAR/WORKSHOP HELD DURING THE MONTH

No	Type of training/Seminar/ Workshop, etc	Subject	Method	Duration	Particip.	Fund Used
1	EPI Peripheral level/Vit.A					
2	EPI MLM/Vit.A					
3	Cold-chain for users/Vit.A					
4	Motor cycle driving					
5	Motor cycle maintenance					
6	Cold chain for technicians					
7	Review meeting					
8	Others (Specify)					

Supervision

No	Area Visited	Purpose

EPI EXPANSION DURING THE MONTH

No	New vaccination site	Strategy		Nature of site			Responsible H/F	Frequency and Day of vaccination	No of Localities/ Kebele Involved	Total Population	Distance from H.F.
		Static	O.R	H/F	P.A	Serv. C					

COMPILED TARGET DISEASES REPORT

Target Diseases	No of Reported Cases and status of Vaccination			Death
	Vaccinated	Not Vacc.	Unknown	
Measles				
Pertussis				
Polio				
Diphteria				
Neonatal Tetanus				
Other Tetanus				
Tuberculosis				
Hepatitis B				
Yellow Fever				

Vaccination/Vit.A Administered in Epidemic/Shelter/etc.

Vaccine/Vit.A Administered	Area	No of Vaccinated/ Supplemented	
		< 1yr	> 1yr

Date of Report: _____
Name of Reporter: _____
Designation: _____
Signature: _____

VACCINE/Vit.A/AD SYRINGES/SAFETY BOXES BALANCES

Vaccine*/Vitamin A/AD syringe/ Safety boxes	Condition			
	Received	Used	Balance	Needed
BCG				
MEASLES				
DPT				
OPV				
TT				
VITAMIN A (10000 IU)				
VITAMIN A (100000 IU)				
AD SYRINGE (BCG)				
AD SYRINGE (OTHERS)				
SAFETY BOXES				

*** Specify the doses of the vials**

PROBLEMS AND SUGGESION/RECOMMENDATIONS

Annex- VI - 1: Checklist for the supervision of EPI activities at health facility level (Example)

a. General Information

1. Name of the health facility: _____
2. Date of Visit: _____ Date of Previous Supervision: _____
3. Name and Responsibilities of the contacted persons:
   a. _____ _____
   b. _____ _____
   c. _____ _____
4. Number of Kebeles: _____
5. Total Catchments area population: _____
6. Target Population for the year: Surviving Infants _____ PW_____ NPW _____
7. EPI Sites: Static: ____ Out reach: ____ Mobile: _____ Total _____

b. Interview and Document Review

No	Activities	Attained (Y/N)
1	Has this health facility set target for surviving infants and women? If Yeas, indicate: a. Surviving infants: _____ b. Women - PW: _____ NPW: _____	
2	Have the entire planned immunization sessions taken place?	
3	Has this health facility monitor its immunization coverage monthly? If yes, Compare the coverage a. G coverage _____ (___%) b. DPT3 Coverage _____ (___%) c. OPV3 Coverage _____ (____%) d. Measles Coverage _____ (____%) e. PW TT2+ Coverage _____ (____%) f. NPW TT2+ Coverage _____ (____%)	
4	Do you administer vitamin A with your routine EPI?	
5	Have the vaccination monitoring charts been used correctly?	
6	Have the vaccination monitoring charts been up dated?	
7	Is dropout rate monitored monthly? If yes compare with National Standard a.DPT1 – DPT3 __%, b. BCG – Measles ____%, c. PW TT1 – TT2 ___%, d. NPW TT1 – TT2 ___%	
8	Is vaccine wastage monitored? If yes compare wastage rate of: a. BCG ____% b. Measles _____% c. DPT _____% d. OPV _____% e. TT _____%	
9	Are cases of (AFP, Measles, NNT, etc) monitored?	
10	Did supervisor visit this health facility in the last quarter?	
11	Is this health facility using appropriate tally sheets and reporting formats?	
12	Are the used tally sheets and reporting formats appropriately filed?	
13	Was the temperature of the refrigerator record twice a day?	
14	Did the temperature of the refrigerator remain between 2 and $+8^0$c Reading of current temperature _____	
15	Are the vaccines stored in the proper compartment?	
16	Is there frozen vaccine?	
17	Is there vial with VVM that has reached discarded point?	
18	Is there vaccine that has exceeded expiry date in the fridge?	
19	Is there vaccine vials with out labels in the fridge	
20	Is there reconstituted vaccine (Measles, BCG) in the fridge?	
21	Is the number of vials of measles/BCG vaccine available is equal to the number of vials of diluents?	
22	Is vaccine stock adequate?	
23	Is vaccine balance sheet/leader used?	
24	Are AD syringes in use?	
25	Are safety boxes used for the needles/Syringes?	
26	Is incinerator in use (Available)?	

No	Activities	Attained (Y/N)
27	Are safe injection standards being maintained?	
28	1. Is reporting complete?	
29	2. Is Reporting Timely?	
C. Observing Immunization Session		
30	Is the immunization status of women and children checked?	
31	Is each injection administered with a sterile syringe and a sterile needle?	
d. Vaccination card review and interviews with the parents		
32	Have the vaccination schedules of women and children and the contraindication policy guidelines been followed today (Review the card or ask parents)?	
33	Are the vaccinators told, when the next immunization date is?	
e. Summary of Major Findings and Recommendations:		
Supervisors:		
Name _____ Designation _____ Signature _____ Date_____		
Name _____ Designation _____ Signature _____ Date_____		

Annex- VI–2: (Example)

Supervision Checklist of EPI activities at Regional/Zonal/Woreda level

A. General Information

1. Name of the Region/Zone/District: _____
2. Date of Visit: _____ Date of Previous Supervision: _____
3. Name and Responsibilities of the contacted persons:
   a. _____ _____ c. _____ _____
   b. _____ _____ d. _____ _____
4. Number of District/Kebele: _____
5. Number of HFs: Hospital; __ HC; ___ HS; ___ HP; __ 6. EPI Sites: Static: ____ Out reach: ____ Mobile: _____
7. Total Population: _____ 8. Target Population for the year: Surviving Infants: _____ PW: _____ NPW: _____

No	Activities	Attained (Y/N)
B. Interview and Document Review		
1	EPI Policy/Guideline document available?	
2	Micro-plans prepared annually?	
3	EPI focal person at district/province level designated?	
4	EPI focal person trained in MLM EPI course /Cold chain/Safety injection?	
5	Target population of district/zone estimated and known by staff?	
6	Annual and monthly targets monitored?	
C. Observations		
7	EPI Coverage monitoring chart displayed?	
8	Cold chain equipment/storing facilities are adequate?	
9	Vaccine supply quarterly is adequate?	
10	Regular cold chain monitoring (twice a day) observed?	
11	Cold chain monitors/indicators in use?	
12	Injection equipment supply is adequate?	
13	Safety boxes supply is adequate?	
14	IEC posters and pamphlets displayed?	
15	Supervisory visit reports available?	
D. Operational Indicators		
16	Report Completeness of health facilities.	
17	Report Timeliness of health facilities	
18	Estimated proportion of children/women immunized for the month/quarter/year: BCG _____ (___%) c. OPV _____ (____%) Measles _____ (___%) d. DPT3 _____(____%) e. PW TT2+ _____ (___%) f. NPW TT2+ _____(___%)	
19	Drop out rate: DPT 1 – DPT3____%; BCG – Measles ____%; PWTT1 –TT2 ___%; NPWTT1 – TT2___%	
20	Is supervision visits undertaken last quarter? If yes mention the number _____	
E. Summary of Major Findings and Recommendations:		
Supervisors:		
Name _____ Designation _____ Signature _____ Date _____		
Name _____ Designation _____ Signature _____ Date _____		