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MINISTRY OF HEALTH-ETHIOPIA

የዜጎች ጤና ለሃገር ብልጽግና!  
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

# **Rapid Community Survey**

**National Standard Operating Procedures (SOPs) for  
Routine Immunization Rapid Community Survey**

**July 2024**



# I. Preface

Immunization is the most cost-effective public health interventions in reducing morbidity, disability, and mortality associated with vaccine preventable diseases (VPDs). In Ethiopia, consecutive demographic health surveys showed steadily increase of immunization coverage and reduction in vaccine preventable diseases. However, since 2020, immunization coverage stagnated due to COVID-19 pandemic, climate change and conflicts. Thus, the vaccine preventable disease incidence showed an increase recently. The survey results showed that, often children in geographically isolated, hard to reach areas and from the poor, uneducated families who are not using the services and not completed vaccination series experience burdens of vaccine preventable diseases. There are also more than millions of zero dose and under vaccinated children across the country; and these children are mainly found in rural remote, hard to reach areas, conflict affected, pastoral, urban slums, and other underserved communities.

Immunization data varies significantly among different data sources like administrative data from HMIS, WUENIC estimations and EDHS in Ethiopia. These data sources except HMIS, which shows high coverage of immunization indicators, cannot be available at sub national/local level to use for action. Denominator used for planning and performance monitoring has a limitation in most places due to old census used for target estimation. Therefore, RCS is locally generated evidence that highlights specific gaps in immunization coverage in specified areas for decision making.

There is also the need to recast monitoring from data to active search to assess the immunization status of children. Relying on numbers and coverage data is not adequate for monitoring and evaluation of service access and utilization. Shifting from data monitoring to measurement of inequities among high-risk community should be practiced.

These are made possible through high quality, sustainable and locally generated data through real time data collection tools like rapid community survey. This data collection tool needs to be standardized nationally and used at all levels for the intended purpose.

The ministry of health acknowledged experts, technical advisors and partners that contributes for the development of RI-RCS SOP.



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Finally, the Ministry would like to acknowledge the following lists of experts for their valuable technical expertise contributions.

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## IV. Acronym

AEFI	Adverse Events Following Immunization
DHIS 2	District Health Information Systems
DO	Dropout
EDHS	Ethiopian Demographic and Health Survey
EPI	Expanded Program of Immunization
FV	Fully Vaccinated
GIS	Geographic information System
HC	Health Center
HDA	Health Development Army
HEW	Health Extension Workers
HF	Health facility
HP	Health Post
IDP	Internally Displaced People
MoH	Ministry of Health
PHCU	Primary Health Care Unit
RCS	Rapid Community Survey
RHB	Regional Health Bureau
RI	Routine Immunization
SOP	Standard Operating Procedures
UNICEF	United nations Children Fund
UV	Under Vaccinated
VFA	Vaccinated for age
VPD	Vaccine Preventable Disease
WDA	Women Development Army
WHO	World Health Organization
WorHO	Woreda Health Office
WUENIC	WHO & UNICEF Estimate of national Immunization Coverage
ZD	Zero Dose
ZHO	Zonal Health Office

## V. Key Terms

***Dropout:*** A child who started vaccination and delayed from receiving next vaccine doses as per national routine vaccination schedule.

***Fully Vaccinated:*** A child who is vaccinated by all vaccines before their first birth day as per national vaccination schedule.

***Under Vaccinated:*** A child who is not vaccinated with third dose of Pentavalent vaccine as per national vaccination schedule, for operational purpose we consider under vaccination for children more than one year old.

***Vaccinated for Age:*** A child less than one year old who is vaccinated with all vaccines for which he/she is eligible for his/her age as per national vaccination schedule.

***Zero Dose:*** A child of above one year old who did not take first dose of Pentavalent vaccine.

# 1. Introduction

Vaccination is one of the most cost-effective health interventions to prevent child morbidity, disability, mortality, and complications from many infectious diseases. The development and introduction of childhood vaccines has been one of the greatest public health achievements in history, underpinning marked progress in child survival and health outcomes.

Immunization program monitoring is a key with ultimate goal of measuring whether the vaccine is reaching every eligible target population.

Globally, regular administrative data, Demographic Health Survey, WHO–UNICEF Estimates of National Immunization Coverage (WUENIC), effective vaccine management assessment, immunization cluster coverage survey, Vaccine Preventable Diseases (VPD) surveillance, vaccine consumption and other source of data has been utilized for immunization program monitoring.

In Ethiopia, the routine immunization data has been reported through the district health management information system (DHIS 2) administratively to track immunization performance at all level. Nevertheless, a number of factors affects the administrative data, making it insufficient to estimate immunization performance at the national, sub-national and local levels. Besides the administrative data, the country also uses other sources of data like the Ethiopian Demographic Health Survey (EDHS) which is conducted every five years to complement the administrative data.

Except administrative data, global and national routine immunization performance monitoring systems could not provide timely, disaggregated data for decision making. The routine data has limitations including inaccurate denominator which is estimated from old Census (2007), sub-optimal data quality, lacking functional GIS for Geo-coding the immunization service delivery points and locating zero doses/missed communities and missing various dis aggregated data.



Thus, the need for a simplified, friendly, robust and institutionalized monitoring tool is deemed for real-time monitoring, identify zero dose and under vaccinated children and service linkage. Reviewing in country experiences from UNICEF supported equity zones, it is paramount to institutionalize and scale up the RI-RCS and guide its standard implementation at scale.

The rationale for introducing RI-RCS tool in the national immunization program monitoring system is:

- Realistic immunization coverage is lacked due to absence of realistic denominator data at national and sub national level.
- Lack of cost-effective and actionable systems to periodically identify ZD & UVC and link them to immunization service to improve immunization coverage
- Data use for decision making at local level needs locally generated evidence
- Multiple and alternative data source is needed to triangulate available data for data quality improvement and immunization program at large
- Strategic and reliable data source is needed for planning and resource mobilization
- Lack of updated local coverage surveys/estimations for program management at sub national levels especially at zonal, woredas and lower levels

The routine immunization rapid community survey will be routinely integrated with supportive supervision and instrumental to mitigate the aforementioned challenges. The tool will be utilized at all levels for the real-time monitoring and decision making for the identified gaps at community level. Moreover, it will give us the opportunity to monitor inequity by conducting community level vaccination survey and disaggregated data by equity indicators, such as sex, place of residence, socioeconomic status and others.

## 1.1. What is Rapid Community Survey (RCS)?

Rapid Community survey is a quick and effective monitoring process that provides more accurate information on how the zone, woreda and kebele or PHCU is doing in terms of vaccination coverage and in identifying barriers to immunization service. It can be conducted during SIAs or routine immunization program. It encompasses a house-to-house data collection on vaccination status of children or other target group, socio economic status and possible barriers to immunization using standard tool, followed by analysis and interpretation of the result and using for action to improve immunization coverage.

## 1.2. Strengths and Limitations of Immunization Monitoring Systems

<b>Data sources</b>	<b>Strengths</b>	<b>Limitations</b>
DHIS 2	<ul style="list-style-type: none"> <li>• Able to collect, analyze, and visualize large amounts of health data, allowing for informed decision-making and resource allocation</li> <li>• Designed to be flexible and customizable, allowing users to adapt it to their specific needs and requirements</li> <li>• DHIS 2 offers powerful capabilities for health information management</li> <li>• Can be used to track individual level data and aggregate data, but in our health system we are using for aggregate data</li> <li>• Highly secured and dependable for HMIS</li> </ul>	<ul style="list-style-type: none"> <li>• Complexity of the system, which can make it difficult for users to navigate and utilize all of its features effectively</li> <li>• The potential for data quality issues, as the accuracy and reliability of the data entered relies on the diligence and training of the users</li> <li>• Data can't be traced to individual level in case of using aggregate data</li> <li>• Resource intensive to keep the data secure, reliable and optimal as it depends on high level skill in data entry, analysis, visualization and use.</li> </ul>
RCS	<ul style="list-style-type: none"> <li>• Simple and user-friendly tool to collect individual data at household level</li> <li>• No need to undertake special sampling procedure</li> </ul>	<ul style="list-style-type: none"> <li>• May not be representative as sampling procedure is purposive sampling which is nonprobability sampling technique</li> <li>• Sample size may not be sufficient to infer to target population</li> </ul>

	<ul style="list-style-type: none"> <li>• Allows to collect data on socio economic and equity indicator</li> <li>• Flexible - May allow to collect additional information</li> <li>• Can be used in large scale and small scale even for selected villages to estimate actual coverage</li> <li>• Data can be traced to individual level and very important to link to health services</li> <li>• Everybody can use it with minimal orientation and at lower cost</li> <li>• Provides evidence at local level for decision making and guides national strategic and operational plan by showing coverage pictures disaggregated locally.</li> </ul>	<ul style="list-style-type: none"> <li>• Can't assess supply side barriers as the survey targeted to households</li> </ul>
EDHS	<ul style="list-style-type: none"> <li>• Provide a comparable, high-quality data base on a wide range of health indicators</li> <li>• Provide the opportunity to assess and measure health service impacts like mortality, morbidity and life expectancy</li> <li>• Representative samples extracted and can be inferred to general community.</li> <li>• Indicators like socio economic characteristics can be assessed.</li> <li>• High data quality is extracted as intensive trainings, monitoring and supervision is done.</li> </ul>	<ul style="list-style-type: none"> <li>• Conducted every five years or more</li> <li>• High cost</li> <li>• Recall bias during data collections on events like morbidity, mortality and others</li> <li>• Quality indicators not assessed</li> <li>• Sub national evidence not available, only national and regional</li> <li>• Can't be done locally for local evidence need.</li> </ul>
WUENIC	<ul style="list-style-type: none"> <li>• Help to assess trends in immunization program performance, to better establish the relationship</li> </ul>	<ul style="list-style-type: none"> <li>• Not available at sub national level</li> </ul>

	<p>between immunization service delivery and disease occurrence</p> <ul style="list-style-type: none"> <li>• Provide a framework for setting future goals for immunization programs (IA2030)</li> <li>• Facilitates having a critical assessment of how well we are doing in reaching every child with life-saving vaccines and meeting goals</li> <li>• Makes it easier for the immunization community to conduct further research and work together in addressing bottlenecks.</li> <li>• Allows examination of the factors contributing to immunization performance</li> </ul>	<ul style="list-style-type: none"> <li>• It is estimate from administrative data, surveys and other conditions and may be affected by:</li> <li>• The availability, quality and timeliness of empirical data informing the estimates</li> <li>• The completeness and accuracy of the admin report</li> <li>• Recording and aggregation of children vaccinated may contain errors</li> <li>• The estimates of target population depend on the availability of recent quality censuses and, in some countries, the completeness and timeliness of birth registration</li> <li>• Surveys can be affected by multiple biases</li> </ul>
CLUSTER SURVEY	<ul style="list-style-type: none"> <li>• Result is more representative as it uses probability sampling technique and weighted analysis</li> <li>• Contribute data to models of the impact of vaccination on disease burden, including risk assessment of outbreak potential</li> <li>• Act as an indicator of program readiness to introduce new vaccines, in particular for receiving support from the GAVI</li> </ul>	<ul style="list-style-type: none"> <li>• More rigorous, more complicated, and in some cases more costly to undertake</li> <li>• Statistical expertise will be needed to conduct weighted analyses, and depending on survey goals, to help with sample size calculations.</li> <li>• Can't be done routinely and difficult to get local data from the findings</li> </ul>
Evaluation or research	<ul style="list-style-type: none"> <li>• Helps to figure out if the program/project has impact</li> <li>• Helps in guiding the program/project to be successful</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to undertake routinely</li> <li>• Needs scientific knowledge and skill to conduct</li> <li>• Costly</li> </ul>

	<ul style="list-style-type: none"> <li>• Informs program/projects progress</li> <li>• Necessary to undertake at any time during or after implementation.</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to undertake at small scale to inform local decision making</li> </ul>
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### 1.3. Implementation scope

The RCS is intended to be implemented by supervisors at all levels of national, regional, zonal, woreda and PHCU level and partners should also use the RCS tool during supervision. The RCS will be expected to be done at list biannually by national and regional teams and woredas and PHCU supervisors should do it on quarterly basis for all kebeles under their catchments.

## 2.Objective

### 2.1. General Objective

To quickly gather key information about targeted children's vaccination status, estimate vaccine coverage, identify areas of low coverage, understand reasons for non-vaccination or under vaccinations and factors contributing for non-vaccination or under vaccination for timely decision making, policy development, designing tailored interventions to improve immunization coverage and ultimately enhance community protection against vaccine preventable diseases.

### 2.2. Specific Objectives

- To estimate vaccination status of target children and vaccination coverage in the community
- To describe the vaccination status of children by socio-economic background
- To identify barriers to routine immunization access and utilization
- To create additional source of information for routine immunization to triangulate with other data sources and using it for decision making, policy impact and tailored intervention
- To link identified zero dose and under vaccinated children to immunization service
- To strengthen the integration of other maternal and child health services with immunization
- To standardize the implementation of Routine immunization rapid community survey.

## 3. Procedure for Implementations of RI-RCS

RCS should be implemented based on some procedures to be successful and provide evidence necessary for decision making.

### 3.1. Planning RI-RCS

**Planning:** RI-RCS is part of the EPI annual work plan where MoH and RHB will oversee the implementation and conduct it biannually.

The zonal health department and woreda health office team in collaboration with other stakeholders should plan and execute RI-RCS on quarterly basis.

At PHCU level, the health center team is required to plan and conduct RI-RCS quarterly and follow up action plan should be developed and used for decision.

### 3.2. Resources Required

Resources required to conduct a rapid community survey in an immunization program typically include:

**Human Resources:** Trained supervisors, surveyors or fieldworkers to conduct the RCS; including interviewing respondents, administering questionnaires, and collecting data. This may also include supervisors or coordinators to oversee field activities.

**Logistical Support:** Transportation, accommodation, and meals for survey teams, especially if the survey involves visiting remote or hard-to-reach communities. This also includes logistical arrangements for equipment and materials needed for data collection.

**Training:** Training sessions for surveyors to ensure they are familiar with survey protocols, data collection tools, ethical considerations, and safety measures. This may also include training on cultural sensitivity and effective communication skills.

**Data Collection Tools:** standard questionnaires or survey instruments tailored to assess immunization coverage, barriers to vaccination, and child/community characteristics. This may include paper-based forms, electronic data collection devices, or mobile applications.

**Communication Materials:** Educational materials or information sheets to inform community members about the survey objectives, procedures, and importance of participation. This may

include flyers, posters, or audiovisual aids in local languages. These tools may be optional as RCS can be conducted in small scale. This tool may be used when RCS is done in large scales.

**Supervision and Quality Assurance:** Supervisory staff to monitor data collection activities, provide support to survey teams, and ensure data quality and integrity. This may include periodic site visits, spot checks, and data validation exercises.

**Data Management:** Systems and processes for data entry, cleaning, storage, and analysis. This may include database software, data entry personnel, and statistical software for analysis.

**Community Engagement:** Resources for community engagement activities to promote awareness of the survey, build trust with community members, and encourage participation. This may include community meetings, focus group discussions, or community leaders' involvement.

### 3.3. Sampling procedures

Through purposive sampling technique, woredas and PHCU could be selected using the set of some criterions. These criterions include physical inaccessible villages/ Rural remote, Pastoral areas, conflict affected areas, urban slum areas, urban outskirts, VPD outbreak affected areas, IDPs, under served and/or marginalized community and others.

*Note: During selection the following points need to be taken into considerations*

Better to consider selection of 30% of zones, woredas, PHCUs and kebeles at all level

Villages will be purposely selected in a kebele

Interview the first selected household, if the household has a child age 0-35 Months

**Note that if more than one eligible child is available in one household immunization status of all children will be assessed and recorded.**

### 3.4. Site selection

Site selection for routine immunization rapid community survey can be done in all villages using purposive sampling with special consideration on the focus areas of:

- Physically inaccessible villages/ Rural remote
- Pastoral areas
- Conflict affected areas



- Urban slums
- Urban outskirts
- VPD outbreak affected areas
- IDPs
- Under served and/or Marginalized community and Others

### **3.5. House Holds Random Selection**

- Go to the central location of the selected Got (ጎጥ) in the kebele
- Select a travel direction at random by spinning a ballpoint pen. That is, spin a ballpoint pen and drop on the ground, and follow the direction of the tip/head of the ballpoint pen pointing.
- Interview the first selected household direction of spine, if it is eligible based on the classification of households and on availability of children by age group (0-35 Months).
- Note that all eligible should be interviewed in selected household and immunization status of all children will be assessed
- Walk in a serpentine fashion within the selected Got (ጎጥ) until you find the required eligible HHs

### **3.6. Sample size**

- It is recommended to consider a sample size of 20 HHs with eligible children 0- 35 months in one kebele preferably in remote Got (ጎጥ) in the kebele during RI-RCS.
- In case of a household having more than one target children, it is advised to assess the status of all eligible children in the household and record all on data collection tool.
- If the required number of households with eligible children (20 per Got) within the selected Got (ጎጥ) is not available, select one of the Got (ጎጥ) adjacent to the first selected Got (ጎጥ) in the same kebele and assess eligible children until 20 households with 0-35 months old children is achieved.

### **3.7. Data collectors/monitors**

When RCS data collection is planned, the purpose, approaches and data collection process should be communicated to Woreda, PHCUs and health posts. Properly well oriented monitor/data collectors should be assigned. Conventionally these data would be collected by any trained health supervisors working at PHCU, WorHO, ZHO, RHB and trained person from

supporting partners. However, immunization service providers at the selected kebeles should not participate on data collection processes. Depending on the situation, teachers, and other multi sector staffs can also be participated as needed provided that they are trained and assigned by respective health authority.

### **3.8. Data collection/monitoring procedures**

Before data collection process preparatory activities should be finalized. Since the collected data should serve as evidence for decision making at local level and then up line structure, proper purposive selection of sites and procedures should be finalized. The following preparatory activities should be under taken before data collection.

- **Situation and data analysis:** different contextual parametric like trends of administrative coverage in terms of access and utilization, occurrence of vaccine preventable diseases outbreaks in the last five years, inconsistent data among antigens and across the years, presence of session interruptions, early identification of difficult to reach areas, previous supply interruptions, Kebele/community feedback and expert opinions would be part of the analysis.
- **Quantification and mapping of required resources:** depending on the local availability of resources, and volume of data collected, early resources mobilization including printing materials, fuels, motorcycle should be secured. Data should be collected by standardized collection tool. ODK collect installed on each supervisor's personal phone/tablet would be the main data collection tool; and in the absence and inapplicable situation, manual form can serve as data collection tool and entered to excel form for analysis and use.
- **Orientation and discussion on identified issues:** after selecting and assigning monitor, appropriate orientation should be given to data collectors in order to familiarize on the tools.
- **Data collection process:**
  - Data collection will be at household level and other places that may target children exist like streets, religious areas up to getting 20 HH/site with eligible children
  - Visit households, greet families in local languages, and ask about the presence of 0-35 months old children (if no, go to the next HH until getting eligible children)

- Ask caregivers if the child/children have received a vaccination or not by using data collection tool.

*Note:*

- Review immunization card and copy all records to the data collection tool
- The primary source of data will be the immunization card/any record at the hand of care givers. If the card is not available, ask caregivers to check vaccination status through history.
- Probe and explore the vaccine received by asking questions like vaccine route of administration, place/site of vaccinations, frequency of vaccinations.
- Data should be collected at HH premises, and the interview should be with mother or caregivers in calm environment with the language they understand well.
- Geo-location points should be taken at the gate of each HH with eligible children assessed.
- HEWs/immunization service provider at kebele level should not go with data collectors during the survey and instead HDAs or other kebele representatives as well as staff from PHCU can go with data collector as needed.

### **3.9. Data analysis and interpretation**

Collected data will be cleaned, analyzed, interpreted, and used for decision-making at all level based on the selected indicators. The finding can be triangulated with other available evidences like DHIS 2, EDHS, WUENIC and other reliable data sources.

### **3.10. Report Write up**

Detailed report of the RCS finding should be done at PHCU, Woreda, zone, region and national level. Household's characteristics, child related factors, socio demographic factors, immunization status of children, calculated coverage, other integrated health service status, and barriers to immunization should be discussed in detail after data collection is completed. Result of data analysis, interpretation, challenges and recommendation should be included in the report including lessons learned from this specific task.

### **3.11. Feedback and data use**

On time feedback Should be given to front-line service providers/HEW, supervisors and other stake holders as necessary. Action plan should be developed immediately at HP level together with data collectors/monitors. Similarly, PHCU level feedback should be given with the presence of PHCU director and program personnel, and action plan should be prepared. (Action plan template attached)

If the supervisors are from MoH, RHB, ZHO, WorHO or EPI supporting partners, written feedback should be provided within a short period of time as much as possible based on their hierarchy at each level and follow up of the agreed action plan should be done as needed based on the survey finding to ensure whether the action is taken or not as per the plan.

Evidence generated through RCS implementation would be used for RED/C micro planning, resource mobilization, advocacy, decision making and other intervention.

The evidence can be used at national level for different purposes if sufficient data is collected and can lead to specific conclusion and decision.

### **3.12. Implementation follow-up**

- At woreda, zonal, regional and national level data should be periodically analyzed and used for follow up of the activities.
- Based on the action plan from survey finding the supervisor/program person is expected to monitor the implementation of planned action plan on regular basis.
- The follow up can also be conducted using remote phone call, performance review, physical observation of register and others as well.
- Identified zero dose and under vaccinated children should be directly linked to immunization service.
- When the next RCS is planned to be conducted the implementation of previously provided feedback should be checked and if the action is not taken it should be justified and re-planned for the next action.

### **3.13. Result Dissemination**

RCS result can be disseminated based on the scope of RCS implementations. The result can be disseminated at all level including PHCU, Woreda, zone, region and national level. The result can be disseminated on performance review meetings, different workshops including planning, monitoring and evaluation workshops, research dissemination forums and others. Feedback from dissemination forums and workshops should be properly collected and utilized as input for immunization program monitoring improvement.

## 4. Monitoring and Evaluation

The RCS assessment should be part of the supportive supervision and expected to be done every quarter by PHCUs, woredas and zonal health offices. Regional health bureau and ministry of health is expected to do it biannually. Every RCS finding should be presented to the corresponding department or management.

Depending on the situation RCS data monitoring dashboard will be prepared and installed for data users and decision-makers.

- Implementation of the action plans, results would be monitored based on the selected key indicators
- The findings can also be reviewed during the integrated monthly review meeting
- PHCU should conduct one RCS per kebele per quarter and is expected to cover all kebeles under PHCU every year at minimum.
- Woreda should conduct one RCS per PHCU per quarter
- Zone should conduct one RCS per woreda per quarter
- RHB should conduct one RCS per zone every six month
- MoH should conduct one RCS per region every six month

✚ One RCS = 20HHs with children 0-35 months old.

✚ Got (ጎጥ)/kebele addressed by RCS by any level supervisor once during the fiscal year should not be addressed again except follow up visit is needed and/or any other issue is raised.

✚ Data collected through RCS can be analyzed and synthesized centrally to provide more information and generalized at large scale

### 4.1. Selected monitoring indicators

√ Number/Proportion of PHCUs/Woredas/Zones/RHBs conducted RCS

√ Number/Proportion of kebeles covered by RCS

√ Number/Proportion of children who received vaccination cards during vaccination

√ Number/Proportion of children who have vaccination cards at the time of data collection

- √ Number /proportion of children who are vaccinated for age
- √ Number /proportion of children who are Fully Vaccinated before their first birth day
- √ Number /proportion of zero dose children identified
- √ Number/proportion of under vaccinated children identified
- √ Number/proportion of ZD/UV children identified and vaccinated
- √ Dominant reason for not vaccinated/ under vaccinated.

## 5. RI-RCS Data Collection Tool

Data elements for RI-RCS (Routine Immunization Rapid Convenience survey)			
1. Residence/Profile		Possible response	Remark
1.1	Date of data collection		Ethiopian Calendar
1.2	Data Collectors name		Text
1.3	Data Collectors organization	MoH, RHB, ZHO, WorHO, HC, Partners	Text
1.4	Data collectors' responsibility		Text
1.5	Name of Region		List
1.6	Name of Zone/town/city admin		List
1.7	Name of Woreda		List
1.8	Name of PHCU		List
1.9	Name of nearby health facility		Text
2.10	Type of health facility	HP/HC/Primary hospital/private health facility	List
2.11	Name of Kebele		Text
2.12	Type of kebele	Urban/Rural	List
2.13	Name of gote/village		Text
2.14	Is the gote/village hard to reach/high risk?	Yes/No	List
2.15	Reasons of hard to reach	Select from list	List
2.16	Name of lead HEW		Text
2.17	Phone number of HEW		Phone number
2. Family Details			
2.1	GPS coordinate of the house hold		GIS coordinate
2.2	Mothers/caretakers name		Text
2.3	Age of mothers/care takers in completed years		number
2.4	Marital status	Single, Married, Divorce, Widowed, Separated	List
2.5	Parity of mother		Number
2.6	Educational status of caretaker	No education, Primary, secondary and above	List
2.7	ANC visit during pregnancy of child under assessment	No ANC, <4 contacts, 4+ contacts	List



2.8	Number of Td vaccination doses the mother took		Number
2.9	Place of delivery	Home, Health facility	List
3:10	Did you get postnatal care after delivery of this child?	Yes/No	
3:11	CBHI enrolment status	Not eligible, Not enrolled, Enrolled and renewed, enrolled but not renewed	List
3:12	Productive Safety Net Program (PSNP) enrolment status	Not enrolled, Enrolled and graduated, currently enrolled	List
3:13	Are you a member of WDA (Woman Developmental Army)	Yes/No	List
3:14	Is your WDA team functional	Yes/No	List
<b>3. Child details</b>			
3.1	Name of the child		Text
3.2	Date of birth	Ethiopian Calendar	Select from local Calendar
3.3	Age of the child in completed months		Age Auto calculate in months
3.4	Sex of the child	Male/Female	List
3.5	Birth order of the child		Number
<b>4. Vaccination history</b>			
4.1	Did the child started routine immunization?	Yes/No	List
4.2	Site of vaccination	HP/HC/Public Hosp, Private HF/OR/Others (Specify)	List
4.3	Is immunization card provided?	Yes/No	List
4.4	Is card available?	Yes/No	List
4.5	Where did you get information for the immunization?	HDA/HW/HEW/Kebele leader/Media/Other community members/Other (Specify)	List
<b>5. Vaccines and doses received</b>			
5	Did the child received the following vaccines?		

5.1	BCG	Yes/No	List
5.2	Hep Birth Dose	Yes/No	List
5.3	OPV 1	Yes/No	List
5.4	Penta 1	Yes/No	List
5.5	PCV 1	Yes/No	List
5.6	Rota 1	Yes/No	List
5.7	OPV 2	Yes/No	List
5.8	Penta 2	Yes/No	List
5.9	PCV 2	Yes/No	List
5.10	Rota 2	Yes/No	List
5.11	OPV 3	Yes/No	List
5.12	IPV 1	Yes/No	List
5.13	Penta 3	Yes/No	List
5.14	PCV 3	Yes/No	List
5.15	Rota 3	Yes/No	List
5.16	MCV 1	Yes/No	List
5.17	IPV 2	Yes/No	List
5.18	MCV 2 (for $\geq 15$ months old)	Yes/No	List
5.19	Vaccination status	VFA/FV/DO/ZD/UV	List
5.20	Reason for not vaccinated/drop out	Select from List	List
5.21	Did other health services provided during vaccination	GMP/VAS/Screening/Deworming/FP/COVID-19 Vaccination/Others (Specify)	List

<b>Hard to reach/High Risk Gote/Community, if:</b>
1=Topography (terrain, mountainous, Rivers, water-logs, no roads)
2=Rural scattered and remote settlements,
3=Urban/Town informal settlements,
4=Migrants, Laborers
5=Street/homeless, temporary shelters,
6=community socially marginalized
7=New urban/Rural settlements, re-settlements/villagization
8=Hot settlements/drought, flood or other disastrous area,
9=Mobile Pastoralist,
10=Ethnic minorities,
11=Special population: religious communities, monasteries, hermits etc.
12=Areas with security problems such as community clashes, border settlements,
13=IDPs
14=Refugees

Reasons for not vaccinated /drop out is presented in the below table.

	<b>Reason for not vaccinated/drop out</b>
1	Unaware of the need for immunization
2	Unaware of need to return for next dose
3	Place and time of immunization unknown
4	Fear of side effects
5	Wrong ideas about contradictions
6	Postponed until another time
7	No faith on immunizations
8	Rumors
9	Place for immunization is too far
10	Time of immunization inconvenient
11	vaccinator absent
12	vaccine not available
13	Long waiting time during the session
14	Mother too busy
15	Family problem, including illness of the mother
16	Family was out of the kebele/Gote
17	Child ill - not brought to vaccination session
18	Child ill - brought but not given immunization
19	Health workers unable to open multi dose vial vaccines for fewer children (BCG & MCV)
20	Other – write as stated by mother

## 6. Annexes

### 6.1. Action plan template

S. N	Problems/Issues identified		Action to be taken	Responsible person	Time frame	Resources required	Remark

### 6.2. PHCU level summary sheet analyses for under one-year children (0-11 months)

Name of PHCU: \_\_\_\_\_

SN	Name of kebele	Name of Got	# of children surveyed	# of children with Cards	# vaccinated P1 for age	# vaccinated P3 for age	# vaccinated MCV1 for age	Pent 1-3 DO (exclude children on P3 appointment)	Pent1-Measles DO (exclude children on P3 appointment)	Remark

### 6.3. PHCU level summary sheet analyses for 12-35months old children

Name of PHCU\_\_\_\_\_

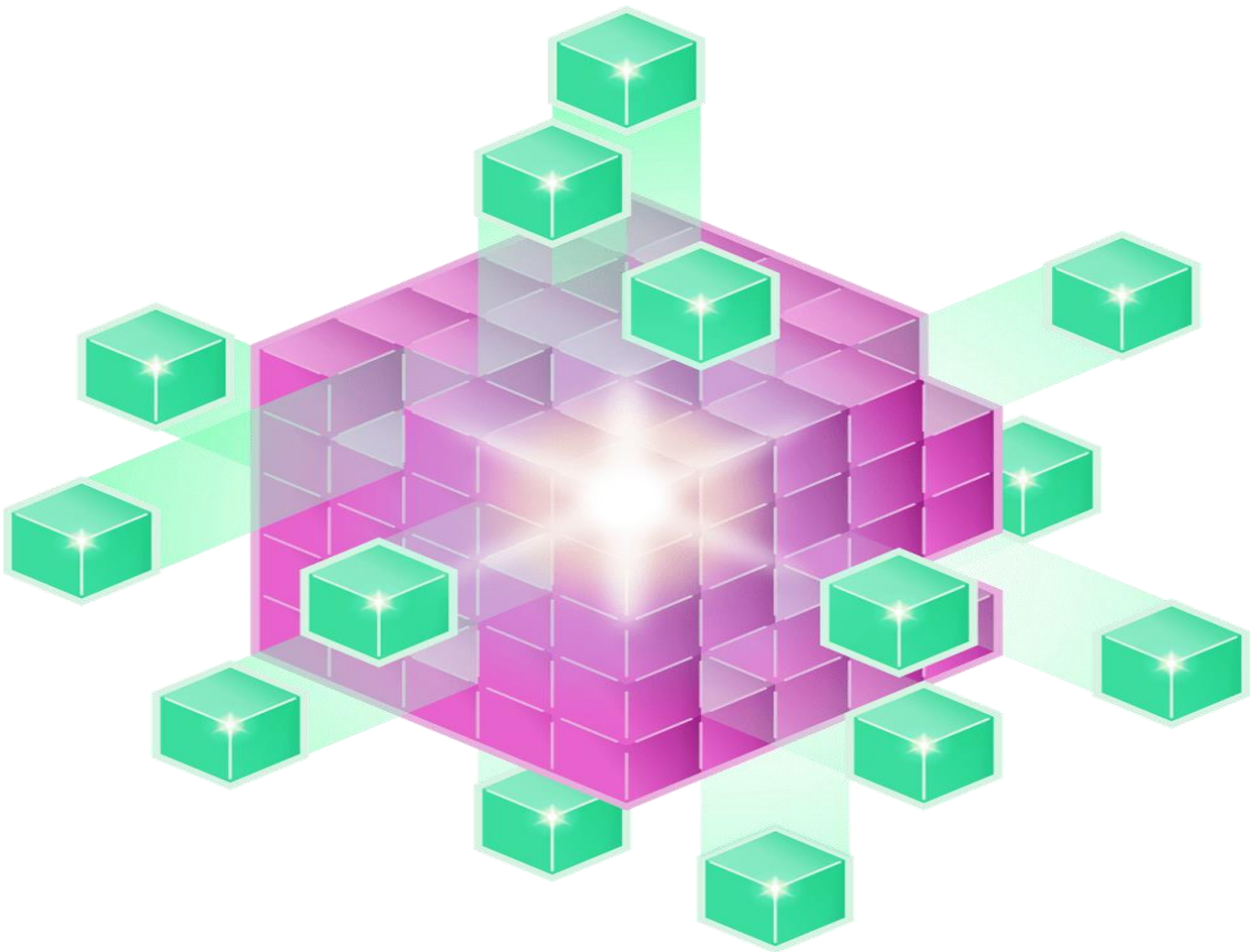
SN	Name of kebele	Name of Got	#of children surveyed	# of children with Cards	# of children vaccinated for P1	# of children vaccinated for P3	# of children vaccinated for MCV1	# of children vaccinated for MCV2	#of ZD

## 7. References

1. Ministry of Health-Ethiopia, National Routine Immunization Catch-up Vaccination guideline, January 2022, Addis Ababa Ethiopia.
2. Ministry of Health-Ethiopia, Immunization in Practice Training manual, September 2023, Addis Ababa, Ethiopia.
3. Immunization Agenda, 2030, A global Strategy to leave no one Behind
4. Ministry of Health-Ethiopia, National Implementation Guideline for Expanded Program on Immunization, June 2021, Addis Ababa, Ethiopia.
5. WHO, vaccination cluster coverage survey, 2018.



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HEALTHIER CITIZENS FOR PROSPEROUS NATION



July 2024

# National Standard Operating Procedures (SOPs) for Routine Immunization Rapid Community Survey