

**National Measles – Malaria Campaign  
Report**

*January, 2007*

**TABLE OF CONTENTS**

<b>1.0</b>	<b>EXECUTIVE SUMMARY .....</b>	<b>5</b>
<b>2.0</b>	<b>INTRODUCTION.....</b>	<b>6</b>
2.1	COUNTRY PROFILE .....	6
2.2	EPIDEMIOLOGY OF MEASLES IN SIERRA LEONE.....	9
2.3	MEASLES CONTROL ACTIVITIES IN SIERRA LEONE .....	9
2.4	MEASLES CONTROL STRATEGIES IN SIERRA LEONE .....	9
2.6	MALARIA CONTROL ACTIVITIES IN SIERRA LEONE .....	10
<b>3.0</b>	<b>GOAL AND OBJECTIVES OF CAMPAIGN .....</b>	<b>11</b>
3.1	Goal.....	11
3.2	Objectives .....	11
<b>4.0</b>	<b>NATIONAL MEASLES MALARIA CAMPAIGN PARTNERSHIP:.....</b>	<b>11</b>
4.1	Campaign Strategy And Setup.....	11
<b>5.0</b>	<b>PRE-CAMPAIGN ACTIVITIES .....</b>	<b>13</b>
5.1	Planning and Coordination .....	13
5.2	Logistics.....	13
5.3	Micro-Planning .....	14
5.4	Social Mobilization .....	15
5.5	Personnel Selection and Training .....	15
5.6	Injection Safety and Disposal Methods .....	16
<b>6.0</b>	<b>SUPERVISION AND MONITORING .....</b>	<b>16</b>
<b>7.0</b>	<b>FINANCE: .....</b>	<b>17</b>
<b>8.0</b>	<b>DATA ANALYSIS .....</b>	<b>17</b>
<b>9.0</b>	<b>IMPLEMENTATION RESULTS .....</b>	<b>18</b>
10.0	LESSONS LEARNT FROM THE MEASLES MALARIA CAMPAIGN .....	24

## Report National Measles Malaria Campaign, 2006.

Report National Measles Malaria Campaign, 2006.

### ACKNOWLEDGEMENT

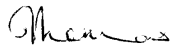
*For the first Nationwide Measles – Malaria campaign to be so successful, it has to have the commitment and dedication of so many partners who put “CHILDREN FIRST” and for that the Ministry of Health and Sanitation is grateful. I will first of all like to thank our health developmental partners namely the World Health Organization, the United Nations Children’s Fund, Canadian International Development Agency, the Canadian and Sierra Leone Red Cross Societies, West African Health Organization, Aware – RH, Vestagard Frensen/ Universal Logistics and the Church of Jesus Christ of Latter – day Saints who were involved in all aspects of the Measles – Malaria campaign.*

*My thanks also go to members of both the Interagency Coordinating Committee and the Country Coordinating Mechanism of both the EPI and Malaria programs. The valuable contributions of the integrated technical committee, task forces and consultants cannot be over emphasized.*

*To the district councils, your contribution and dedication to the national fight to reduce illnesses and deaths among children under five years old was demonstrated by the role that you undertook in the implementation of the campaign and I am sure this great partnership will be maintained in our strive to achieve the Millennium Goal.*

*I say “bravo” for a job well done to the Ministry of Health personnel especially members of staff of both the MCH/EPI and National Malaria Control Programmes.*

*Finally appreciation is extended to parents and caregivers for without them coming out to the post, this event would never have happened.*

  
Mrs Abattor Thomas  
Minster of Health and Sanitation

## **LIST OF ACCRONYMS**

CIDA.....	Canadian International Development Agency
DHMT.....	District Health Management Team
EPI.....	Expanded Program on Immunization
ITNs.....	Insecticide Treated Bednets
IDSR.....	Integrated Disease Surveillance and Response
IEC.....	Information, Education and Communications
IMCI.....	Integrated Management of Childhood Illnesses
LLINs.....	Long Lasting Insecticide Treated Bednets
MCH.....	Maternal and Child Health
MOHS.....	Ministry of Health and Sanitation
NMCP.....	National Malaria Control Programme
NGOs.....	Non – Governmental Organization
UCI.....	Universal Child Immunization
UNICEF.....	United Nations’ Children Fund
WAHO.....	West African Health Organization
WHO.....	World Health Organization

## 1.0 EXECUTIVE SUMMARY

The Ministry of Health and Sanitation in collaboration with partners conducted a nationwide Measles – Malaria Campaign on the 20<sup>th</sup> – 26<sup>th</sup> of November, 2006. The campaign was integrated and involved a four prong interventions of Measles vaccination, Vit A supplementation, Mebendazole (de-worming tablet) administration and the distribution of Long Lasting Insecticide Treated Bednets. The overall goal of the campaign was to reduce morbidity and mortality due to Measles, Malaria, worm infestation and micronutrient deficiencies in children less than five years of age. The goal will be obtained through the following objectives;

- 95 % coverage of children 9 – 59 months with Measles vaccine
- 95% coverage of children 6 – 59 months with Vitamin A
- 90% coverage of children 12 – 59 months with Mebendazole
- 80% coverage of children 0 – 59 months with Long Lasting Insecticide Treated Bednets

The target population involved **all children less than five years old** in Sierra Leone and they received one or more of the four interventions according to their ages. Strategies implemented during the campaign were static, outreach and mobile teams. A total of 1,634 vaccination teams made up of at least 4 people took active part in the campaign. They consist mainly of medical personnel from the Ministry of Health and Sanitation and health institutions. Volunteers of the Sierra Leone Red Cross Society and the Church of Jesus Christ of Latter – day Saints complemented the activities of the vaccination teams. Also of significance was the active role taken by the district councils which created a sense of ownership. The concept of Independent Monitors who are non – Ministry of Health personnel that was introduced in the 2005 National Immunization Days for Polio was also incorporated in the Measles – Malaria Campaign. The coordination of the activities were at national and district levels. At national level, the overall coordination was by the Interagency Coordinating Committee and the Country Coordinating Mechanism for both MCH/EPI and the National Malaria Control Programmes respectively. Members of the district council, district health management team and other health developmental partners make up the district coordinating committee at the district level.

Coverage attained during the campaign for Measles vaccination, Vit A and Mebendazole administration and the distribution of Long Lasting Insecticide Treated Bednets were 100.4%, 100.5%, 98.7% and 98.9% respectively. The national Measles vaccine wastage rate was 3%. The proportion of children not immunized nationally was 5%. Reasons for non – immunization were refusals, sick children, long absences and others. The most effective means of information dissemination about the campaign were from the airing of radio skits and drama, health personnel and town criers.

The campaign created an integrated partnership among all partners which must be sustained order to reduce morbidity and mortality among children under five years of age in Sierra Leone.

## 2.0 INTRODUCTION

To achieve the Millennium Development Goals of reducing morbidity and mortality amongst children under five years due to Measles and Malaria, high coverage of immunization and Malaria prevention and control interventions is core.

Malaria control and Immunization programmes share a common commitment to improve child and maternal health, primarily through preventive interventions, and are high on the public health agenda in Sierra Leone. These are demanding in terms of human and financial resources, and they also seek to achieve the highest possible coverage rates in the country. Based on experiences from other countries and the successes achieved, the Government of Sierra Leone through the Ministry of Health and Sanitation (MOHS) conducted an integrated child survival campaign focused on Measles vaccination, administration of Vitamin A and Mebendazole, and the distribution of LLINs to achieve a rapid scaling-up of ITNs coverage for children under the age of five years.

The integrated campaign was designed as a cost effective integrated package and facilitated partnership among committed partners in health. In addition, the involvement of district councils created a sense of ownership.

## 2.1 COUNTRY PROFILE

### *Geographic location and Climatic information:*

Sierra Leone is located on the West Coast of Africa, and is bounded by Guinea on the North and East, and Liberia on the South (see administrative map below - Fig 1).



## *Report National Measles Malaria Campaign, 2006.*

The Atlantic Ocean forms a beautiful coastline to the south and west of the country. The country has a varied topography ranging from coastline swamps, through inland swamps and rain forest to one of the highest mountains (Bintunani - 2200m) in West Africa. More than half of the country lies below 150m above sea level. The vegetation is mainly secondary palm-bush, interspersed with numerous swamps that are mostly cultivated for rice. These swamps provide ideal breeding places for the Anopheline vectors of Malaria. Moreover, the capital city Freetown has several mangrove swamps, which provide the breeding sites for *Anopheles melas* mosquitoes, which is one of the major vectors of Malaria besides *gambiae* and *funestus*.

The country has a tropical climate with temperature ranging from 21°C to 32°C with a mean daily temperature of 25°C. It has two major seasons; wet season (May to October) and dry season (November to April) with heavy rains in July/August. It has an average rainfall of about 3200mm annually. Relative Humidity is high ranging from 60 to 90%. (Annual Statistic Digest 2001). The condition favours the breeding of mosquitoes and high Measles prevalence in the month of May. Administratively, the country is divided into four provinces, namely Northern, Southern and Eastern provinces, and the Western Area where the capital, Freetown, is located. The provinces are further divided into thirteen (13) districts, while the districts into chiefdoms. The District Councils consisting of the district chairman, administrators and councillors oversee the activities of the districts; while the chiefdoms are governed by locally elected paramount chiefs.

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***Demographic and Health information:***

Basic demographic data including vital statistics are as shown in Table 1 below. Remarkable improvement is expected in the years ahead as the country moves into recovery phase and progressively into development phase.

*Table 1: Main demographic features and Health indices of Sierra Leone:*

<b>Indicator</b>	<b>Latest Estimated Value (See sources*)</b>
Population: Total	5,177,937 (2006 projection)
Population: under five years	880249 (17%)
Population: pregnant women	258897 (5%)
Population: Non-pregnant women	983808 (19%)
Female population	51.9%
Male population	48.1%
Crude birth rate	48 per 1000 population (W. Africa av. =34/1000)
Crude death rate	23 per 1000 population (W. Africa av.=11.5/1000)
Average annual growth rate	2.0%
Total fertility rate	6.2 birth/woman
Infant mortality rate	170 /1,000 live births
Under five mortality	286/1,000 live births
Maternal mortality rate	1800/100,000 live births
Underweight prevalence in U5 children	17.2%
Stunting prevalence U5 children	33.9%
Wasting prevalence in U5 children	9.8%
Malaria treatment in U5 children	60.9%
ITNs usage by U5 children	10.3%
Access to basic health care (actual)	38%
Urban dwellers	40.2%
Rural dwellers	59.8%
GDP per capita	USD 142
Life expectancy in years	43 years

\*Sources: Statistics Sierra Leone 2004

## **2.2 EPIDEMIOLOGY OF MEASLES IN SIERRA LEONE**

The epidemiology of Measles in Sierra Leone is similar to that in other countries in the West African block, with more cases being observed during the drier months of February, March and April, and number of reported cases falling off sharply with the onset of the rains. Knowledge of this information made the implementation of the campaign to be conducted in November, which is a period of low transmission in order to achieve sero-conversion before the following peak transmission season.

## **2.3 MEASLES CONTROL ACTIVITIES IN SIERRA LEONE**

Measles control activities started in Sierra Leone in 1975 when the Expanded Programme on Immunization (EPI) was first introduced. Coverage remained very low until the push towards Universal Child Immunization (UCI) started in the late 80s. Coverage of 75% was recorded in 1990, which was the UCI target year. From then immunization coverage as a whole took a downward trend because of a drop in donor funding. This situation was made worse by the decade long civil conflict in the country which led to the destruction of most of the health infrastructure and the displacement of health personnel. Since the war officially ended in 2001, Government with support from partners has been doing everything possible to resuscitate immunization services, including activities that will lead to a reduction in Measles morbidity and mortality. The control effort was further boosted in 2003 with the mass Measles catch up campaign, which recorded high administrative coverage. An independent coverage survey could not be carried out to validate the reported coverage. The planned follow up campaign for 2006 was another effort to move the process forward.

## **2.4 MEASLES CONTROL STRATEGIES IN SIERRA LEONE**

### **1. *Improving routine immunization:***

Every effort has been directed at improving routine immunization services since the secession of hostilities in 2001. The coverage figures are beginning to look up again after the downward trend witnessed for most of the last decade. The cumulative coverage for 2005 was 67%.

### **2. *Conducting supplemental activities:***

In 2003, a catch up campaign was done targeting children 9 months to fifteen years with Measles vaccine and as a result this follow- up campaign was designed targeting 9 – 59 months. This integrated campaign is one of the few done in West Africa involving four interventions consisting of Measles vaccine, administration of Vitamin A and Mebendazole plus distribution of LLINs.

### **3. *Improving case management, including Vitamin A supplementation and Mebendazole:***

Vitamin A supplementation and administration of Mebendazole for de-worming have been part of the Polio campaign activities for many years and have been introduced into routine immunization since 2003. High coverage has been recorded. Efforts are now being directed at accelerating the introduction of the Integrated Management of Childhood Illnesses (IMCI) strategy in the country, which is one of the ways in which improvement in Measles case management can be assured, particularly during confirmed Measles outbreaks. Micronutrient deficiency and malnutrition continue to be public health concerns

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in Sierra Leone. The global malnutrition rate is 46% among children under five, 34% are stunted, 27% are underweight and 10% are wasted.

#### **4. *Strengthening Measles surveillance:***

There are serious gaps in the data available through routine reporting, probably because of the breakdown in the system during the period of conflict. Attempts are being made to resuscitate the system with gradual introduction of Integrated Disease Surveillance and Response (IDSR) with Measles as one of the priority diseases.

### **2.6 MALARIA CONTROL ACTIVITIES IN SIERRA LEONE**

In an attempt to reduce the high morbidity and mortality due to Malaria in the country, and to coordinate the efforts of various groups to control this disease, the MOHS established a National Malaria Control Programme (NMCP), under the Directorate of Disease Prevention and Control in 1994. Malaria is ranked as the number one cause of morbidity and mortality in Sierra Leone especially in children under five years of age. Mortality attributed to Malaria is 38.3% among children aged five years and below and 25.4% for all ages.

One of the key strategies for reducing the burden of Malaria is the regular use of Insecticide Treated Nets (ITNs). Several control studies in Africa have demonstrated that regular use of ITNs can reduce child mortality by more than 20%. The use of ITNs is one of the most cost effective interventions in the prevention of Malaria. The Ministry of Health and Sanitation has endorsed the use of ITNs as one of the key strategies for reducing the high burden of Malaria. In Sierra Leone, only 10.3 % of children under five years and 12.5 % of pregnant women are sleeping under ITNs (baseline survey 2005).

### **3.0 GOAL AND OBJECTIVES OF CAMPAIGN**

#### **3.1 Goal**

The overall goal of the campaign was to reduce morbidity and mortality due to Measles, Malaria, worm infestation and micronutrient deficiencies in children less than five years of age.

#### **3.2 Objectives**

The objectives of the campaign were to achieve:

- 95 % coverage of children 9 – 59 months with Measles vaccine
- 95% coverage of children 6 – 59 months with Vitamin A
- 90% coverage of children 12 – 59 months with Mebendazole (De-worming tablet)
- 80% coverage of children 0 – 59 months with LLINs

#### **4.0 National Measles Malaria Campaign Partnership:**

The MCH/EPI Division and the National Malaria Control programme of the Ministry of Health and Sanitation in collaboration with Health Developmental Partners designed and supported the campaign. The following major developmental partners supported the campaign:

-  World Health Organization
-  United Nations Children's Fund
-  Canadian International Development Agency
-  Canadian and Sierra Leone Red Cross Societies
-  West African Health Organization
-  The Church of Jesus Christ of Latter Day Saint
-  Aware – Reproductive Health
-  Vestergaad Fransen/Universal Logistic Company

#### **4.1 Campaign Strategy and setup**

The campaign employed a combination of static, outreach and mobile teams to reach the target population. A team consisted of at least 4 personnel, comprising of 2 vaccinators, one person to do the screening and crowd control while the fourth person did recording and issuing of nets. A total of 1, 634 vaccination teams were recruited nationwide for the implementation of the campaign. The site set up consisted of:

- One person may do the screening and crowd control
- Another administered the Vit A and Mebendazole
- Another administering Measles vaccine
- And the fourth issued the bed net and mark the fingers of both the child and the child and the mother (see annexe).

Tallying was done by the personnel administering the intervention for accuracy. Red Cross and the Church of Jesus Christ of Latter Day Saint volunteers complemented the effort by the team by assisting with crowd control and screening, bednet distribution and finger marking and health educational activities. In certain sites, Vestergaad Fransen/Universal Logistic Company re- enforced the importance and use of the bednet by utilizing drama groups and other social mobilization techniques in the form of football matches.

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The role of the screener was to:

- Welcome the parent/guardian and child (ren)
- Ensure effective identification of children for each intervention
- Allocates interventions according to age of child
- Fills out campaign card clearly, efficiently and effectively
- Maintains order within the vaccination post
- Answers questions if asked
- Directs guardians and caretakers to the appropriate next intervention

After the mothers/caregivers have been given the net, they were educated about the use of the net and told to retain the campaign card until 8 weeks later after the coverage survey.

## **5.0 PRE-CAMPAIGN ACTIVITIES**

### **5.1 Planning and Coordination**

Major partners met at the beginning of 2006 to revise and finalized the proposal for the National Measles Malaria Campaign. An integrated technical committee was created which consisted of partners and the technical wings of both MCH/EPI and NMCP of the Ministry of Health and Sanitation. Sub-committees with specific terms of reference were also created and they report directly to the technical committee. The following were the sub-committees created:

-  Operation
-  Admin and Finance
-  Training
-  Logistics
-  Social Mobilization
-  Resource Mobilization
-  Disease Surveillance

The integrated technical committee in turn reported to a higher coordinating body i.e Interagency Coordinating Committee for EPI and Country Coordinating Mechanism for Malaria both chaired by the Honourable Minister of Health and Sanitation. The integrated technical committee and sub-committees met once a week in the beginning and twice weekly in the last two months to the campaign.

In addition, teleconferences facilitated by WHO were held monthly at the start and then fortnightly in the last two months to the campaign.

### **5.2 LOGISTICS**

The logistics committee designed logistic plans for vaccines, bednets and other support items for the campaign. The plans were reviewed by the technical committee and implemented accordingly.

#### **5.2.1 Cold Chain Equipment and Measles vaccine supply**

One hundred percent of the country is now completely solarized and all districts are equipped with a district cold room and a functional generator at the time of implementation. There were 650 solar refrigerators installed by the campaign period. Adequate ice packs, cold boxes, and vaccine carrier were available in all districts. As a result of the above, all districts were equipped to maintain the cold chain for the maintenance of the potency of the vaccine. A total of 850,000 doses of Measles vaccine were procured by UNICEF for the campaign and distributed to the districts with the districts' population of children within the ages of 9 – 59 months as a guide.

#### **5.2.2 Bed net**

A total of 875,000 Long Lasting Insecticide Treated bed nets (LLINs) were donated by the Canadian Red Cross through funding from CIDA and pre – positioned by the districts with support from the Canadian Red Cross. The nets were pre-positioned one month to the campaign as they were the most bulky item to transport. A memorandum of understanding was signed between the DHMTs, Council members, senior members of the Ministry of Health and

Sanitation and the Red Cross Society for the pre - positioning of the bednets. This created a sense of ownership between the DHMTs and the council members.

### **5.2.3 Other Logistics Items**

Indelible ink makers, mixing and Auto Destruct syringes, safety boxes, flyers, posters, banners, Tee shirts, aprons, tally/summary/supervisory/monitoring forms, training manuals were in position in all districts prior to the trainings.

Support for the campaign was also given by Non – governmental Organizations in the respective districts in the form of transportation, social mobilization activities ect.

### **5.3 Micro-Planning**

A well coordinated and efficient micro – planning was done both at national and district level in order to have a quality Measles and Malaria campaign. The objective of the micro planning was to develop a detailed plan of resources needed and strategies to effectively cover each district for the campaign. The training for the micro planning was top-bottom while the development of the plan was bottom-top in approach. The National Supervisors facilitated micro planning in all the districts. During the orientation of the National Supervisors for the micro planning, a micro –planning package was prepared for them with technical input from WHO and UNICEF. The micro planning package consisted of:

- Welcome note to the participants.
- Agenda for the orientation and a proposed agenda for the district micro – planning.
- Population projections of the four different ages involve in campaign
- Copies of all the presentations given during the orientation.
- Copies of the micro – planning tools.
- Deliverables after the district micro – planning.

In addition to hard copies, electronic copies of the micro –planning package was also given to all participants.

A district level micro planning session, which involved team supervisors, zonal coordinators, NGOs and the community, was conducted. This was followed by National micro planning involving the District Health Management Teams, National Supervisors, district council members, representatives of partners and NGOs. The aim of the workshop was to examine and harmonize micro plans developed by each district and collate them into a national plan.

### **Outcome**

- Micro plan and budget prepared by district
- Strategies to be employed in a catchment area
- Resource requirements and gaps identified
- Daily schedules prepared by vaccination team and supervisor
- Daily schedule prepared by supervisor for data collection and forwarded to upper level
- Waste management plan prepared by district, including daily schedule for safety boxes collection, transportation, storage and burning (See annexe).

#### **5.4 Social Mobilization**

Advocacy was conducted at all levels. At national level, sensitization was done for Political, Religious, NGOs, and Community leaders through meetings, workshops and task force briefings. Advocacy packs were distributed to Parliamentarians. At district level, District Administrators, Traditional and Opinion Leaders were also sensitized.

Information, Education and Communication (IEC) materials were developed and pre-tested by the social mobilization committee to facilitate dissemination of messages at all levels. Materials developed and disseminated were: Posters, brochures, leaflets, flyers and banners. Radio jingles were also produced in various tribal languages and distributed to all FM/community radio stations for broadcasting prior to and during the campaign nationwide. Other strategies including the use of local drama groups, street to street announcement by volunteers, towncriers and community motivators were used.

Community sensitizations were conducted at district and chiefdom levels, to increase demand for immunization and ensure proper utilisation of LLINs. The role of the communities was clearly defined especially with regards to facilitating distribution of LLINs. Red Cross and Members of the Church of Jesus Christ of Latter Day Saint were trained and active in mobilising communities.

All these activities yielded very high levels of community awareness and participation, and high levels of support from NGOs and other partner agencies.

#### **5.5 Personnel Selection and Training**

Integrated cascade training was done at three levels. At national level, a training of trainers was undertaken for national level supervisors. National supervisors, in turn, trained DHMT as district and Zonal supervisors. District and Zonal supervisors trained vaccinators and distributors. Trainings were done using revised and integrated guides which were developed based on WHO/UNICEF guidelines, facilitated by the Technical Committee with technical input from the Consultants. All trainings were interactive in nature.

In addition, Independent Monitors were trained to monitor the quality of the campaign. This is a borrowed idea from the 2005 NIDS as an independent assessment. One of the roles of the Independent Monitor was to monitor the set procedures for quality. They consist of non – Ministry of Health personnel from training institutions and line ministries.





Personnel selection of vaccination teams were done mainly by members of the DHMT and the respective communities. The technical vaccinators were mainly medical personnel from the Ministry and Health and health institutions nationwide. Other members that complemented the teams were from the community, the Red Cross Society and the Church of Latter Day Saint volunteers. The complementing partners mainly assisted in crowd control, social mobilization, bednet distribution and information dissemination.

### **5.6 Injection Safety and Disposal Methods**

Injection safety materials and other disposable items were disposed of appropriately. All Auto Destruct materials and other disposable materials were collected in safety boxes and bags respectively. These were disposed of at all district headquarter towns. Incinerators were used where available, while burning and burying were employed in sites without incinerators.

### **6.0 Supervision and Monitoring**

Supervision was carried out at all levels. The National Supervisors supervised the district supervisors and the vaccinators. They were responsible for the following:

-  Training of district and Zonal supervisors
-  Support and supervise training of vaccinator
-  Assist with the planning and implementation of all activities related to the campaign
-  Provision of daily updates regarding targets and supplies to the National Coordinating Level.

The district supervisors were responsible for the supervision of team supervisors and vaccinators. They monitored all their activities and report to the district coordinating team and national supervisor on a daily basis. They utilized the integrated supervisory package during the campaign.

The Independent Monitors also monitored the implementation process starting from the second day of the campaign. They employed the process of In-process monitoring during the campaign and End-process monitoring a day or two after the campaign. The purpose of the In-process was to identify any missed child under five years old which will then be communicated to the district so that the area will be covered. The end process actually gives a more accurate perception of the implementation process. Two independent Monitors were assigned to each of the fourteen districts nationwide.

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**7.0 FINANCE:**

Below is a table showing funding organizations and corresponding line of support

<b>PARTNERS</b>	<b>FUNDING AREA</b>
WHO	Coordination, training and national launching and float parade , fielded in a full time consultant
UNICEF	Procured vaccines, Vit A, Mebendazole . produced campaign Tools, aprons, t –shirts, and forms, 50% operational cost
Canadian/ Sierra Leonean Red Cross Societies/CIDA	Procured nets and supported pre – positioning, consultants fielded in, support teams during implementation and social mobilization activities, supported coverage survey.
WAHO	Supported national and district social mobilization activities, redistribution of bednets and other logistics
AWARE – Rh	Supported national and district micro –planning
The Church of Jesus Christ of Latter – day Saints	Supported social mobilization activities in the areas of advocacy, float parade, launching
Vestergaard Fransen/ Universal Logistics Company	Social mobilization in the form of flyers, posters, T- shirts, caps,
District Councils/Government Contribution	50% operational cost

**8.0 DATA ANALYSIS**

Key integrated data management tools for the campaign were developed by the Ministry of Health and Sanitation with technical support from WHO, UNICEF and the Red Cross Society. The data management tools designed were:

- Measles tally sheet.
- Vit A and Mebendazole Tally sheet.
- LLIN tally sheet.
- Summary forms.
- Supervision checklist
- Campaign cards

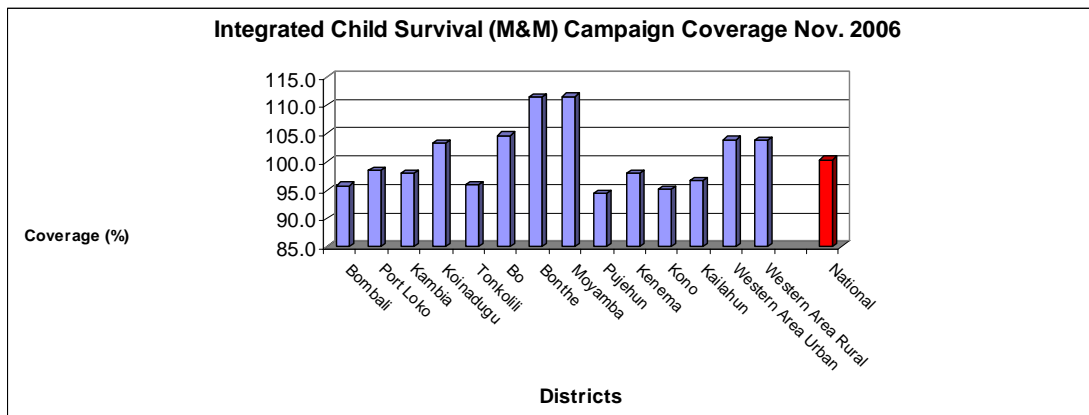
The tally sheets were filled by members of the vaccination teams and submitted to the team leader who after summarization submits the forms to the zonal supervisors. The zonal supervisors in turn submit the forms to the district M/E officers or district coordinating team who collates and report to the national coordinating office. Daily reporting to the national coordinating office was done everyday by all districts.

Monitoring checklists were also designed for use by the National supervisors and Independent Monitors. This was designed to ensure that procedures are done correctly, supplies were adequate and that no child will be missed in a particularly catchment area. Daily updates were given to the DHMT either during the daily coordination meetings or by phone if the National Supervisor or Independent Monitor was far from the headquarter town.

## 9.0 IMPLEMENTATION RESULTS

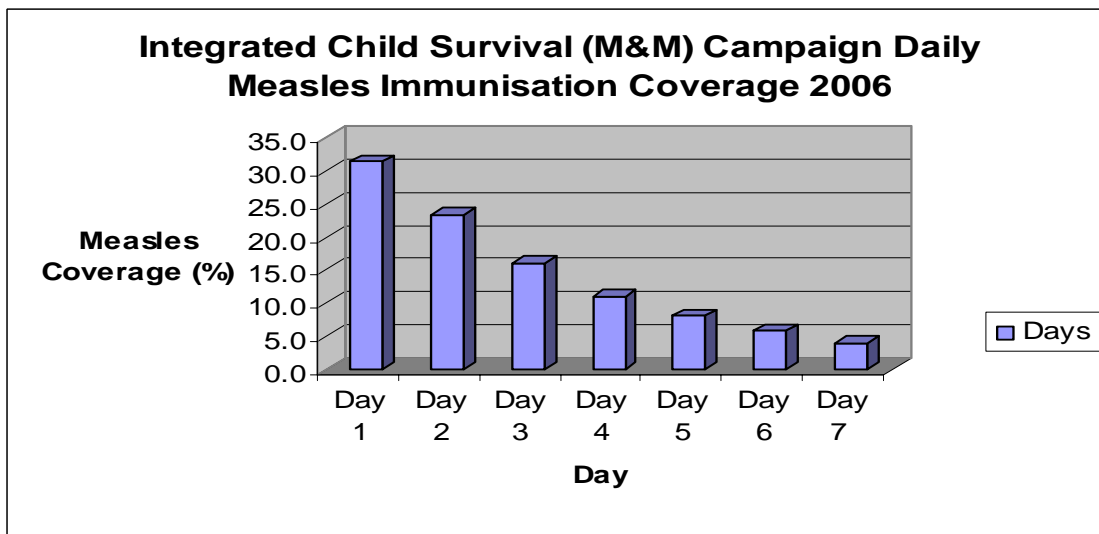
The implementation took place from the 20<sup>th</sup> – 26<sup>th</sup> of November with the exception of few districts who extended for one more day due to redistribution of bed net as a result of shortage. Supervision and monitoring of the campaign started immediately by officials of the Ministry of Health and Sanitation and the National Coordinating Office, National and District Supervisors and partners. The Independent Monitors started their monitoring activities on the second day and ended two days after the end of the campaign.

CHART 1



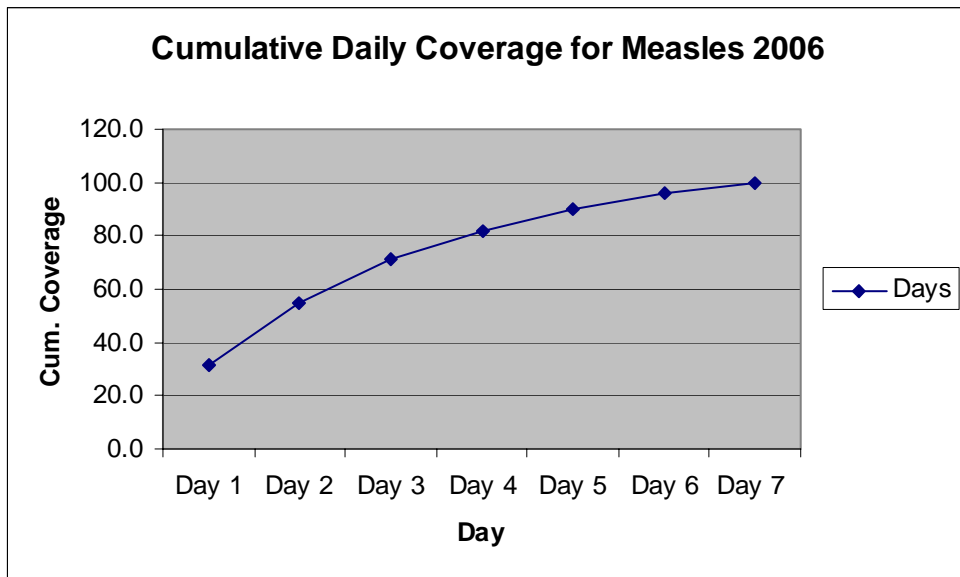
As shown in chart 1 above, the national coverage for Measles vaccination was 100.4%. The coverage ranged from 94.4% to 111.6%. A total of 751,107 children between 9 to 59 months were vaccinated. The national daily coverage of Measles vaccination as illustrated in Chart 2 below from day 1 to 7 were 30.1%, 23.4%, 16.1%, 11%, 8.1%, 5.8% and 3.9% respectively. Similar patterns were seen with the daily coverage of the other three interventions.

CHART 2



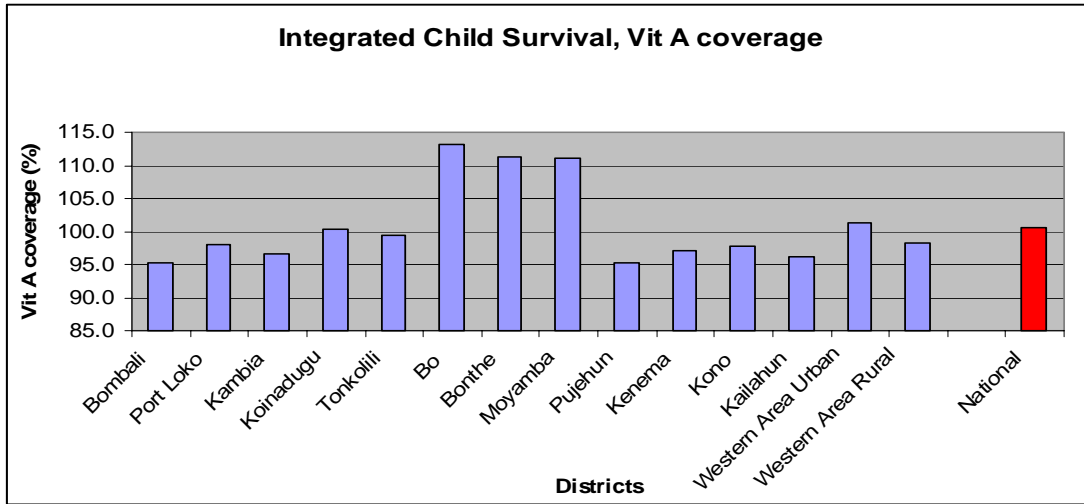
The coverage starts to plateau from the fifth day (see cumulative chart 3). The Measles vaccine wastage was 3%

CHART 3

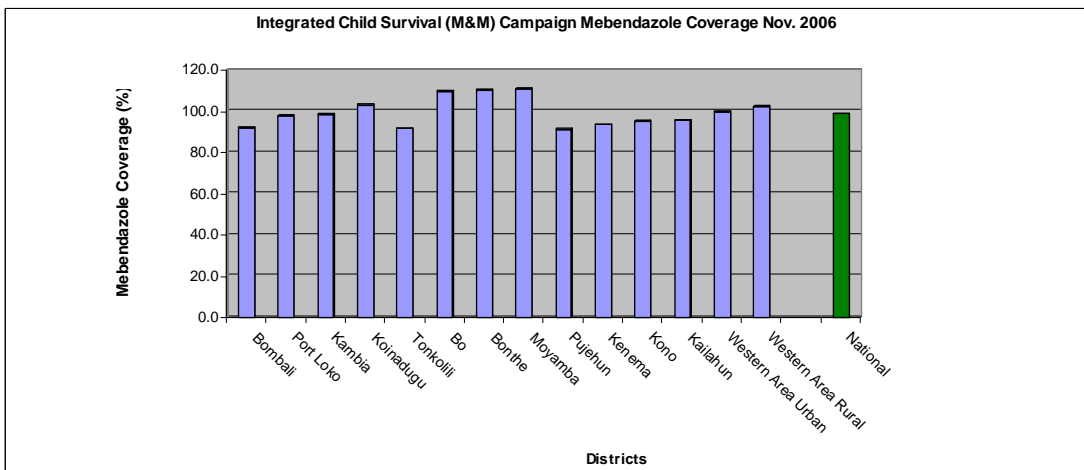


796, 509 children aged between 6 – 59 months were reported to have received Vit A supplementation giving a national coverage of 100.5%. All districts had coverage of greater than 95% (see Chart 4). The National Mebendazole (Deworming tablet) coverage was 98.7% and range from 92% to 111% as shown in chart 5.

**CHART 4**

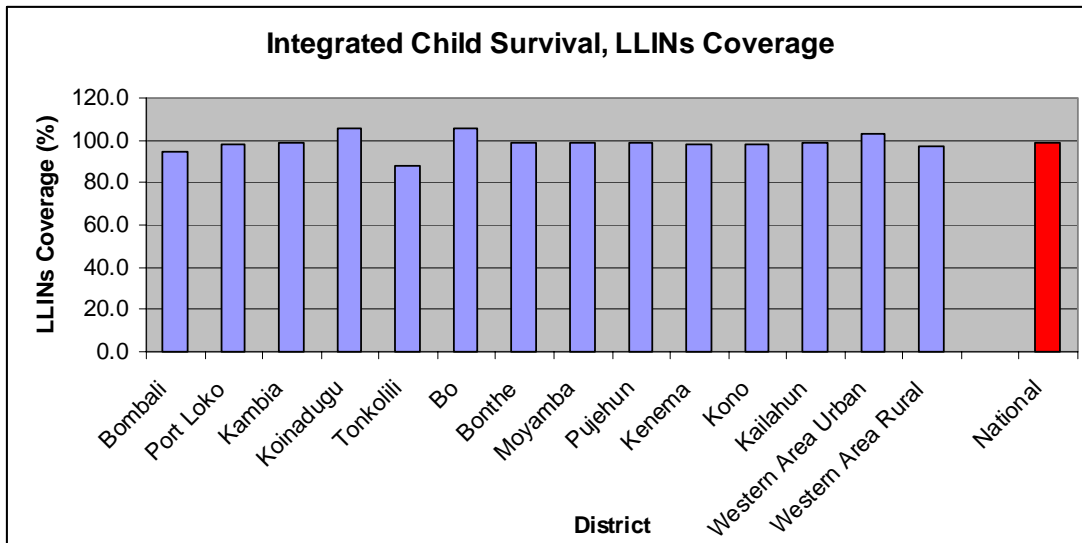


**CHART 5**



Similarly to the National Mebendazole coverage, the national coverage for the LLINs was 98.9% (see chart 6). It range from 87.8% in Tonkolili district to 106% in Koinadugu district. Additional bed nets were supplied to four districts (Western Area, Port Loko, Kambia and Koinadugu) from the existing stock from the Global Fund The reason for the additional supply was due to acute shortage observed midway though the campaign in those districts.

CHART 6



**Coverage Indicators (Based on Rapid Assessment)**

The Independent Monitors conducted rapid convenient sampling of households at the end of the campaign (End – process). A total of 2,841 households with 4,088 and 5,539 eligible children between the ages of 9-59months and aged 0-59months respectively were visited. Data from this exercise was analysed and the finding are as outlined in the chart below:

**Summary of coverage indicators are as follows.**

Percentage of children in the household visited who were not immunised = 5%

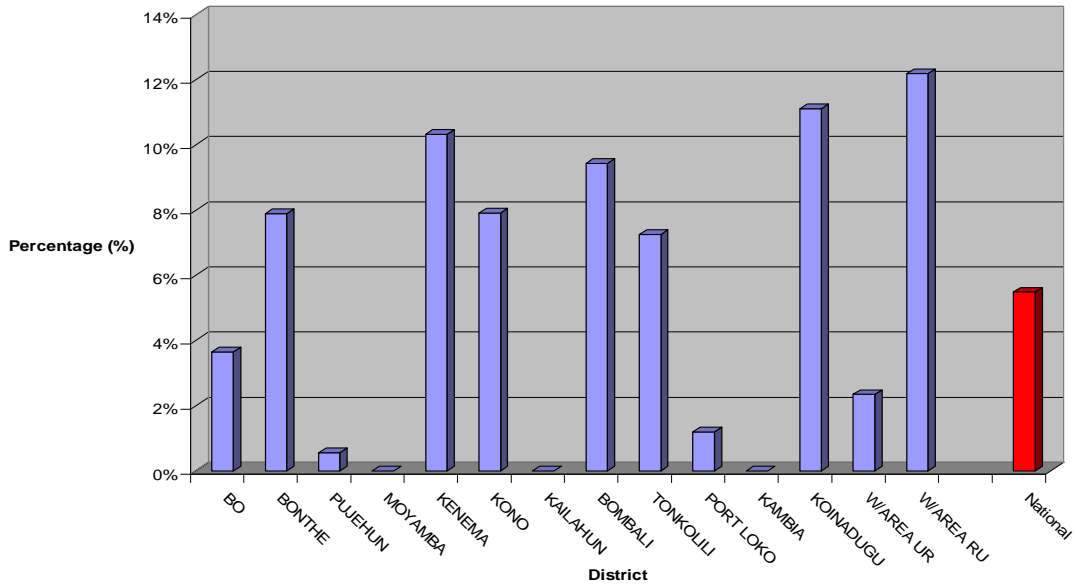
<sup>1</sup>Percentage of children 0-59 in the households visited that received LLIN = 51%

Percentage of parents in the households visited aware of campaign = 52%

<sup>1</sup> The distribution of LLINs was to a maximum of two per female headed household, this however changed during the campaign to one per female headed household in the course of the campaign for reasons of shortage

**CHART 7**

**Proportion of Children not Immunised**



The proportion of children not immunised range from 1% in Moyamba and Kailahun districts to 12% in Western Area Rural. This may be attributed to the following reasons:

- Refusal mainly due to shortage of bednets especially in the Western Area, Koinadugu and Kenema (11.6%)
- Sick children (4%)
- Long absences (9.5%)
- Others(10.4%) see Fig 1

FIG 1

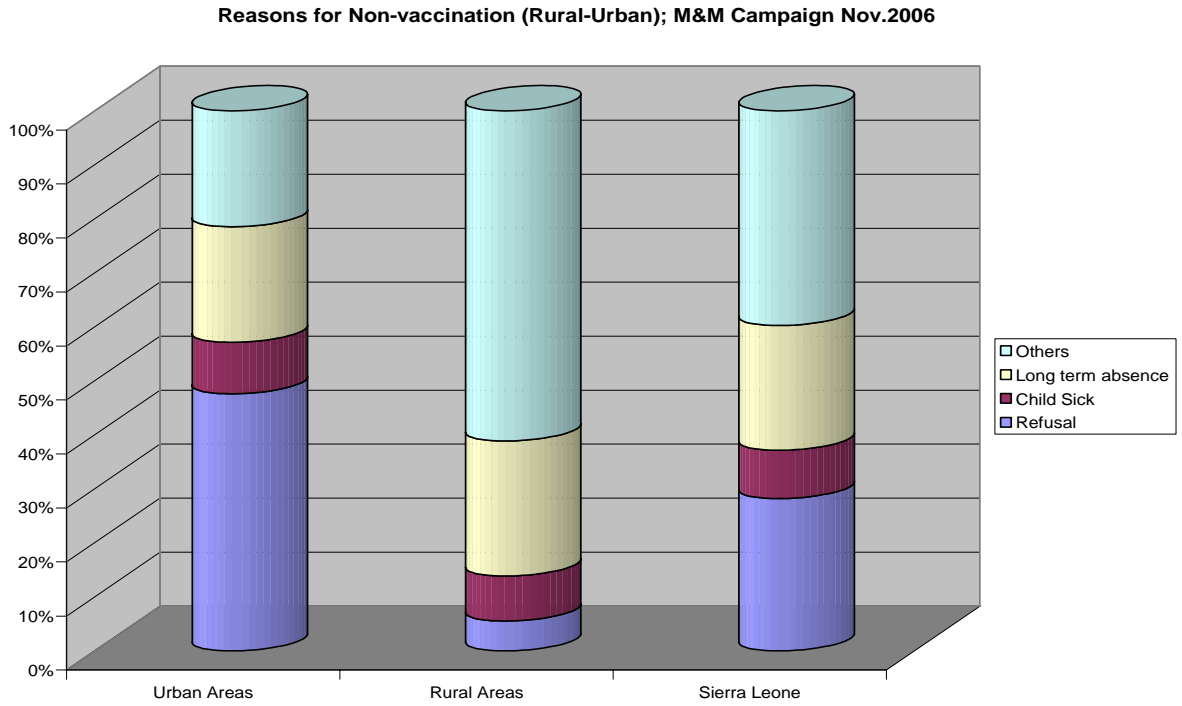
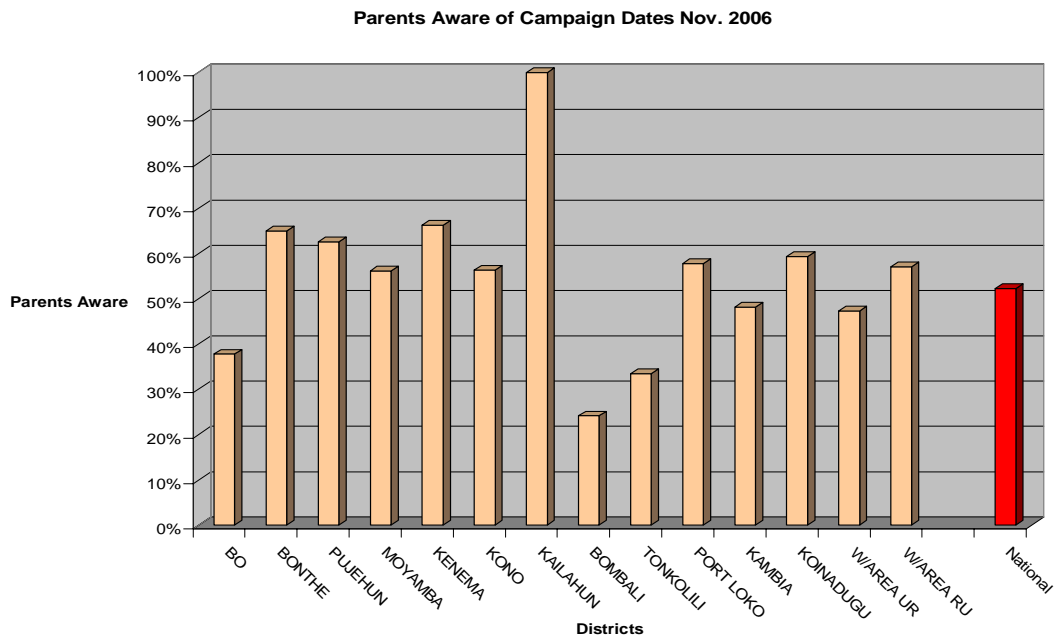


CHART 8



## *Report National Measles Malaria Campaign, 2006.*

As shown in the chart above, fifty two percent of parents nationally were aware of the campaign before the implementation dates. This was exceptionally high in Koinadugu district where 100% of the households sampled knew about the campaign before implementation. This may be partly responsible for the high turnout that was observed and the rapid shortage of bednets that occurred.

Sources of information dissemination were the radio, mobilizers/town criers, religious leaders, health personnel and from neighbors. It was shown that the radio, health workers and town criers were the most effective means of information during the campaign scoring 56%, 58% and 38% respectively.

In conclusion, the results from the Measles – Malaria campaign shows that the campaign was a success as all the objectives were met.

### **10.0 LESSONS LEARNT FROM THE MEASLES MALARIA CAMPAIGN**

The 2006 National Measles – Malaria Campaign was the first integrated child survival campaign in Sierra Leone involving numerous partners who were dedicated to make the campaign a success. In addition, it was the first campaign where the district councils participated proactively. The following lessons were learnt:

- Leadership as that showed by the Minister played a key role in the success of the campaign.
- Partnership is essential for the success of a campaign.
- The involvement of partners early in the planning stages of the campaign contributed to its success as it creates partnership which may be sustainable.
- Effective planning and coordination made implementation more efficient.
- Establishment of a coordinating mechanism facilitated better planning.
- Detailed logistic plan and early and appropriate social mobilization activities contributed to the success of the campaign.
- The involvement of the government and district councils gave them a sense of ownership in its implementation.
- Integrating the two programs was cost effective as it involved four interventions which achieved their set targets.
- To implement four interventions at the same time was very exhaustive but seeing the recipients receiving the interventions created a sense seeing planning on paper into reality.