

Evidence

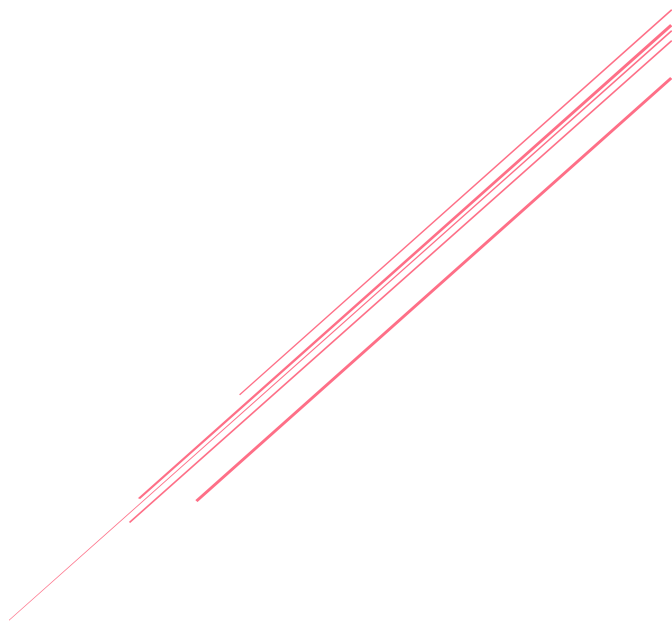
Action



Deworm the
World Initiative

School-based Deworming in Ogun State, Nigeria

Process Monitoring and Coverage Validation
Report



November 2019 Round

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Glossary

FLHF. Frontline health facility

FMOH. Federal Ministry of Health

LGA. Local government area

MDA. Mass drug administration

NTD. Neglected tropical disease

SAE. Severe adverse event

STH. Soil-transmitted helminths

WHO. World Health Organization

1.0 Executive Summary

In November 2019, Ogun state carried out its second round of school-based deworming for the year, the third year of deworming in Ogun, targeting both enrolled and non-enrolled children, ages 5-14 years. Treatment was given in ten local government areas (LGAs) endemic for both soil-transmitted helminths (STH) and schistosomiasis. The state targeted **4,789** public and private primary and junior secondary schools for deworming, and approximately **839,272** children.

Evidence Action monitors the key implementation processes before, during, and after each MDA to assess the effectiveness of training and supply chain, adherence to deworming protocol, and treatment coverage to inform program design and improvements. Evidence Action recruited an independent firm to collect data from a sample of 27 teacher training sessions, 30 schools on Deworming Day, and 73 parents in the communities.

On average, 67% of expected schools were in attendance for teacher training, which was 7 percentage points lower when compared to the last round of deworming in Ogun (74%). The majority of schools that did not attend indicated that they or the teachers were not aware (39%), the venue was not central (22%), and information about the training was received late (17%). The best covered topic during training was on reporting forms, with coverage of key topics noted in 90% of training sessions. In post-training interviews, 80% of participants correctly responded to questions about this content area. Read more on training on [page 8](#).

All schools (100%) had received drugs prior to Deworming Day, and 90% of participating schools had sufficient drugs to deworm all children on Deworming Day. However, only 83% of participating schools had all the key materials, including drugs, on Deworming Day. Read more on distribution on [page 13](#).

Overall awareness of Deworming Day was higher among parents of enrolled children (93%) as compared to the parents of non-enrolled children (62%). Ninety-three percent of parents that were aware of deworming indicated that they would be sending their children for deworming. Of the 4 (7%) parents that said they would not send their children for deworming, the main reason cited was drugs were not offered (50%). The main source of Deworming Day information cited by parents were children (73%) and teachers (69%). Read more on awareness on [page 14](#).

The rate at which schools conducted deworming was low, with only 70% of expected schools distributing tablets on Deworming Day, down from 83% in round 1. All teachers provided the correct mebendazole dose, while most used the tablet pole for praziquantel dosing (93%). However, using the treatment register to record treatment was limited to 63% of schools. Deworming Day observations also indicated that non-

enrolled children were dewormed in only 10% of monitored schools. Read more on drug administration on [page 15](#).

Table 1: Key Performance Indicators

	Percent
Target schools represented at teacher training	67%
Target schools with adequate drugs during deworming	90%
Target schools utilizing at least one awareness activity or material	96%
Parents who report seeing or hearing about deworming through IEC deworming materials or word of mouth this round	93%
Target schools distributing tablets on Deworming Day - STH	70%
Enrolled children present in school on Deworming Day	80%
Targeted children who report receiving unprogrammed deworming in the last six months	NA ¹
Target population validated as swallowing albendazole tablets on Deworming Day based on coverage validation	NA
Target population validated as swallowing praziquantel tablets on Deworming Day based on coverage validation	NA

Conclusions: Overall, round two deworming implementation was successful, highlighted by high post-training knowledge of teachers on worms and target population, drugs and drug administration, and a good supply chain with all key materials available in 83% of schools on Deworming Day. However, there were also challenges that should be addressed ahead of the next round of MDA, including the low rate of observed schools conducting deworming, more comprehensive coverage of topics by trainers in teacher training, and increasing the reach of non-enrolled children. The full summary of successes, challenges, and recommendations can be found on [page 16](#).

2.0 Background

Evidence Action provides technical support to the Ogun state government as it conducts school-based deworming through mass drug administration (MDA) for school-age children (SAC) in a bid to control parasitic worm infections. In November 2019, the second round of its third year of state-wide school-based deworming took place in ten out of 20 LGAs in Ogun state which are endemic for STH and/or Schistosomiasis.

A total of **839,272** enrolled and non-enrolled children aged 5-14 years were targeted to receive deworming treatment in both public and private primary and junior secondary

¹ This is collected during coverage validation, which was not conducted during round 2 in 2019.

schools. Teachers (4,537 in total) were trained to properly administer the safe and effective deworming drugs, mebendazole and praziquantel.

Evidence Action recruited an independent firm, Infotrak Research and Consulting, to monitor random samples of program activities to assess the quality of implementation, adherence to protocol, and supply chain effectiveness. During this round, monitors observed 27 teacher training sessions, 30 schools on Deworming Day, and interviewed 73 parents. Evidence Action designed data collection tools and sampling methods, and cleaned and analyzed the data from the above activities. The findings are presented in this report.

3.0 Methodology

3.1 Process Monitoring

Process monitoring was conducted in the 10 LGAs that conducted deworming. A random sample of 27 teacher training sessions (out of 201) and 30 schools implementing deworming (out of 4,791) were monitored. The sample sizes were calculated to meet a 90% confidence level and a margin of error of 15%, distributed across all LGAs based on the number of activities happening in each LGA.

At every teacher training session sampled, one trainer was interviewed, four participants (teachers) were targeted for interviews before the training, and four participants after the training. The participants interviewed were systematically sampled so that every third participant to arrive at the venue was interviewed pre-training and every third participant to receive training materials was selected for post-training interview.

On Deworming Day, the monitors conducted interviews at the sampled schools with the following individuals:

1. Head teachers, to assess their knowledge of deworming, frontline health facility (FLHF) staff engagement, deworming preparedness, mobilization, and availability of deworming materials.
2. A member of the deworming team (usually a teacher), to ascertain their knowledge of deworming and the activities they conducted in preparation for deworming.
3. One parent who brought their children for deworming, to understand their experience with deworming.
4. Three children (two enrolled children from the class register and one non-enrolled child). This was conducted in one randomly selected class.
5. To assess the effectiveness of the community mobilization and sensitization methods, two systematically selected households with enrolled children and one

household with non-enrolled children within the school catchment area were interviewed.

6. Finally, monitors observed one class while deworming occurred to assess adherence to guidelines, such as the recording of treatment, administration of the right dosage to the correct age-group, and deworming steps. Monitors also made observations to assess school infrastructure, including WASH facilities, presence and location of sensitization materials, and where deworming took place.

Coverage evaluation surveys were not implemented for this round of deworming as they are only conducted during one of the two rounds per year. **Table 2** below shows the targeted and achieved sample sizes for the monitoring activities.

Table 2: Process monitoring targeted and actual sample sizes

Monitoring activity	Population	Target sample size	Actual sample size
Teacher training			
Total number of teacher training sessions	201	27	27
Pre-training interviews		108	108
Post-training interviews		108	108
Deworming Day			
Schools monitored	4,791	30	30
Head teachers interviewed	4,791	30	30 ²
Parents interviewed		30	10 ³
Enrolled children interviewed		60	60
Non-enrolled children interviewed		30	3 ⁴
Community Mobilization			
Households surveyed - Parents of enrolled children		60	60
Households surveyed - Parents of non-enrolled children		30	13 ⁵

² Of the 30 schools sampled, 20 were replaced and monitored. The reasons for replacement: 9 did not deworm, 2 did not exist, 4 were deworming at a later date, 3 could not be assessed, and 2 could not be located.

³ On DD, monitors found parents in school during deworming in only 10 of 30 schools monitored.

⁴ On DD, only 10% of schools monitored had non-enrolled children present during deworming.

⁵ Monitors could only identify 13 households where all the children between the age of 5-14 are not enrolled in any school.

4.0 Results

4.1 Review of teacher training

Of the 27 teacher training sessions that were observed, all (100%) trainers reported that they had been trained at LGA training prior to conducting teacher training. SMS (70%) and phone calls (70%) were the most common means of inviting participants for the training sessions. An attendance sheet was available in only 77% of training sessions.

To share information and keep participants engaged, trainers are encouraged to use a combination of training methods. All (100%) training sessions employed lecture based presentations, while many also employed other methods such as group discussions (81%), group work (59%), demonstrations (22%), and role playing (19%).

4.1.1. Attendance during the teacher trainings

On average, 27 teachers were expected to attend each training, but only an average 19 (67%) attended, representing 67% of the expected schools. The noted attendance rate is 7 percentage points lower than that in the first round of 2019. The majority of the schools that did not attend indicated that they or the teachers were not aware (39%), the venue was not central (22%), and information about the training was received late (17%).

During this round, only 25% of participants arrived after training had started, which was a significant improvement from the first round in 2019, when 56% of teachers arrived late. From post-training interviews, teachers that arrived late indicated that they had to get to school first (58%), travel a long distance to the venue (28%), and received invitations late (18%).

4.2 Topic coverage at teacher training

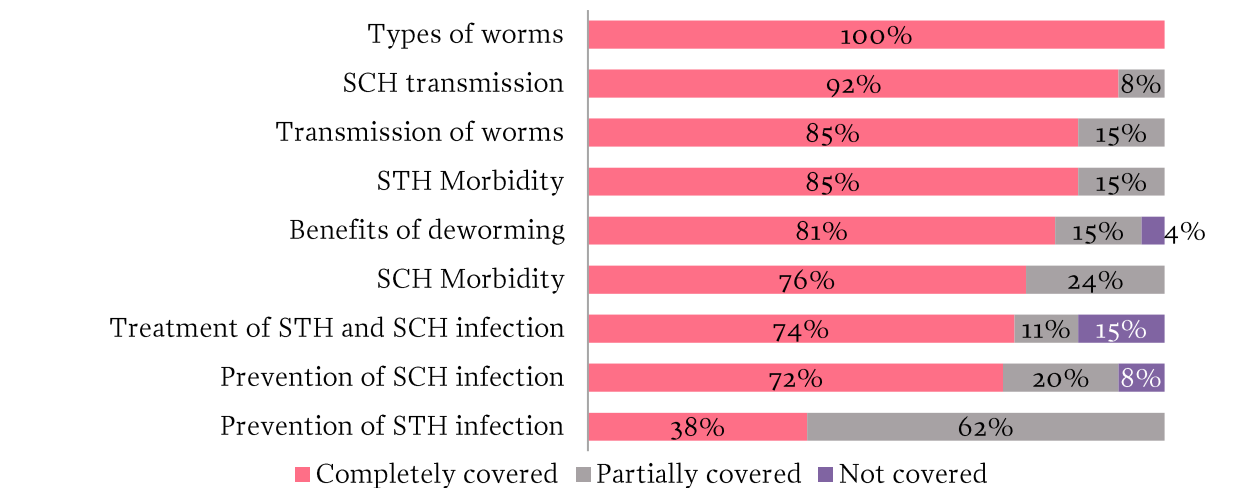
Seven topics are required to be covered in the training sessions, which are discussed in detail below. For the purposes of this report, the seven topics are compacted into five thematic areas. Monitors assessed the coverage of individual messages as well as participants' pre- and post-training knowledge levels.

During training observations, the monitors had a checklist with which to indicate if a topic was either covered completely, partially covered, not covered, or if wrong information was delivered. "Completely covered" means all the information and messages in a given topic were relayed. The sections below discuss coverage of key content that trainers should have delivered during training.

4.2.1 Information on worms and target population

The six messages regarding worms include type of worm, transmission, prevention, morbidity, treatment, and benefits of deworming. Among these, only information on type of worms received complete coverage in all (100%) training sessions, with most other messages completely covered in at least 70% of training sessions. However, complete coverage of the message on STH infection was restricted to only 38% of training sessions (Figure 1).

Figure 1: Messages covered under worms (n=27)



Post-training, all (100%) participants could cite at least one way a child gets infected with worms, 14 percentage points up from 86% in pre-training interviews. Post-training interviews also showed that 97% of the participants could cite the type of worms being treated, a 6 percentage point increase from that noted during pre-training.

Only 78% of trainers covered the target group, which consists of all enrolled and non-enrolled children aged 5-14 years. In addition, three training sessions did not convey this content at all, while another three did not specify the maximum age limit. All training sessions emphasized the importance of not deworming sick children, while under-age children and those with a history of certain health conditions also were mentioned in 81% and 74% of monitored sessions, respectively. These messages are key to minimize the incidence of SAEs.

After training, 98% and 96% of participants cited the correct target age-group for treatment of both STH and schistosomiasis, up from only 49% and 45%, respectively, in pre-training interviews. However, 5% percent of participants incorrectly said that they would deworm sick children present during the MDA.

4.2.2 Drugs and Drug Administration

The coverage of key messages under the drug administration topic was moderate (covered in at least 70% of sessions). Messages on schistosomiasis and STH received were however highly covered (at least 90%) - **Table 3**.

Table 3: Messages on drug administration covered during the teacher trainings (n=27)

MDA practice	Percent (Completely and partially covered)
Schistosomiasis drug is praziquantel	100%
One to five tablets to be given to each child for schistosomiasis depending on height	100%
Under no circumstances should a child be forced to swallow the medicine	96%
Ensure that child has eaten prior to administration of praziquantel	96%
Under the program, all drugs are free, safe and effective	93%
STH drug is mebendazole	92%
One mebendazole tablet to be given to each child	92%
Register enrolled children prior to Deworming Day and non-enrolled children on Deworming Day, prior to treatment.	89%
Drugs must be stored in a clean, safe, dry and cool location	78%
Facilitate hand washing prior to treatment	70%

From post-training interviews, all (100%) participants were knowledgeable about the correct drugs and dosage used for STH treatment, with increases of 51 and 43 percentage points, respectively compared to pre-training. Knowledge of the correct schistosomiasis drugs (98%) and dosage (96%) was equally high, with increases of 64 and 58 percentage points, respectively.

Apart from knowing the right drug type and dosage, it is important to carefully follow certain drug administration steps. Each individual step was described in at least 56% of training sessions, with 93% covering them in the right order. **Table 4** below lists steps, in the correct order, as completely or partially covered during the training sessions.

Table 4: Drug administration steps covered during training (n=27)

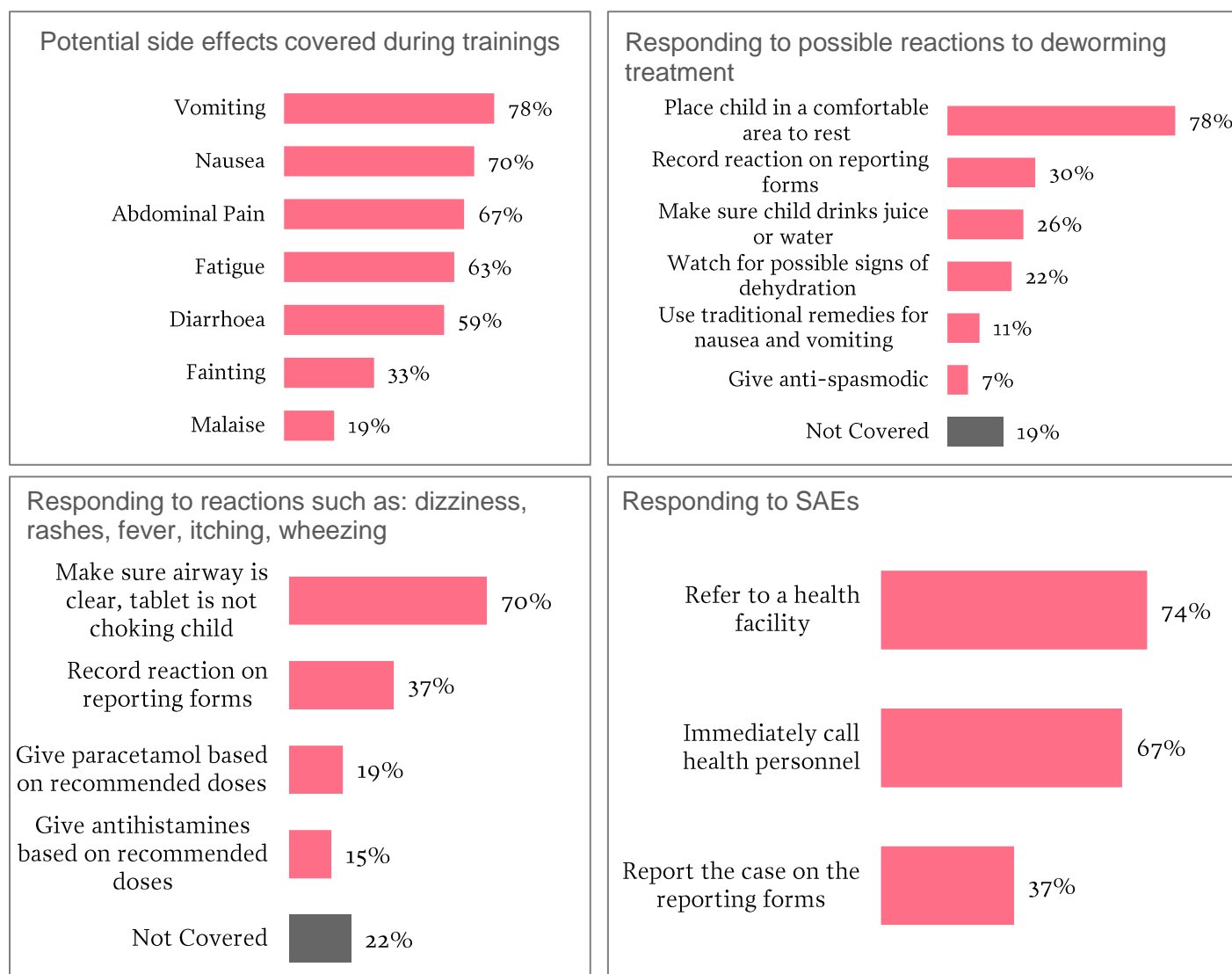
Drug administration step	Completely covered	Partially covered
Step 1: Arrange the drug distribution site	67%	15%
Step 2: Ensure necessary materials are available and are in place	78%	11%
Step 3: Provide orientation to the children	78%	4%
Step 4: Organize children accordingly	70%	7%
Step 5: Let the child wash his/her hands	56%	15%
Step 6: Register the child if non-enrolled	67%	22%
Step 7: Use of tablet pole to measure children's height	88%	12%
Step 8: Administer the mebendazole drug	56%	7%

Step 9: Administer the praziquantel drug	92%	4%
Step 10: Complete registration in the treatment register	89%	11%
Step 11: Observe the child for any side effects	70%	22%

4.2.3 Side effects

Trainers provided information on potential side effects and SAEs to prepare teachers for the management of such situations. Vomiting was covered in 78% of the training sessions, while fainting and malaise were covered in only 33% and 19%, respectively. Further information on knowledge of side effects and SAEs is reflected in the **Figure 2** below.

Figure 2: Messages on side effects (n=27)

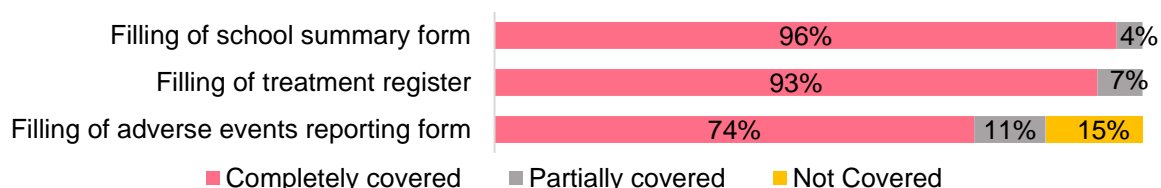


From post-training interviews, vomiting was most mentioned by 77% and 70% of the participants as the likely side effects of STH and schistosomiasis respectively, likely because it was mentioned by all trainers.

4.2.4 Recording and reporting forms

Teachers are required to record the number of children treated at class and school levels on the given reporting forms to ensure accurate treatment coverage rates. Trainers completely covered information on the school summary and treatment register forms in 96% and 93% of sessions, respectively (Figure 3). Practical sessions to fill both the treatment register and school summary form were held in 89% of training sessions monitored.

Figure 3: Messages covered under recording and reporting forms (n=27)



From post-training interviews, 80% of teachers correctly identified the treatment register as the primary form they would use to record treatments. However, 57% of the participants were not able to cite it as the source document for the school summary form.

4.2.5 Roles and Responsibilities

Overall, teacher roles and responsibilities during deworming were covered in most training sessions, apart from mobilization of non-enrolled children. The coverage of the roles of frontline health facility staff and NTD coordinators were poorly covered. Table 5 below provides details.

Table 5: Key MDA roles and responsibilities of various actors covered at the trainings (n=27)

Roles and responsibilities	Percent
Key teacher roles	
Form recording and reporting	96%
Organizing drug administration	93%
Disseminating health education messages to children and parents	78%
Mobilization of non-enrolled children	59%
Key FLHF staff roles	
Managing side-effects	74%
Managing, referring and reporting any children with SAEs	59%
Participate in community awareness creation	52%
To communicate the rationale of the intervention to community leaders	33%
NTD coordinator and educational secretary roles	
Distributing appropriate quantities of drugs to teachers	59%
Receiving any unused drugs from the schools post-treatment	44%

Compiling the treatment coverage report	41%
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From post-training interviews, 83% of teachers correctly identified the role of FLHF staff in the management of SAEs.

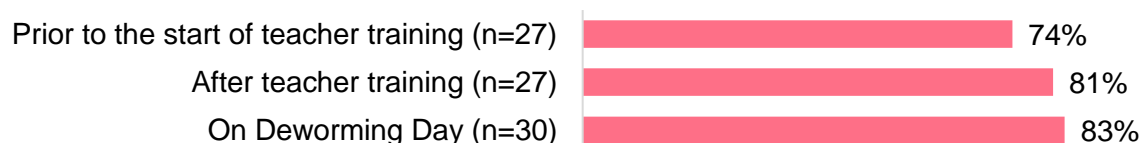
4.3 Distribution of drugs and materials

Trainers should receive key materials before training (drugs, reporting forms, tablet poles, and posters) to aid in teacher training sessions, as well as to pass on to teachers.

In all (100%) training sessions, drugs for both STH and schistosomiasis treatment were available before the sessions began, and were distributed in all training sessions. Most sessions had tablet poles (89%) before training started with distribution to 92% of the teachers from schools in attendance. Distribution of reporting forms was also high, treatment registers in 85% and schools summary forms in 93% of training sessions. A teacher training handout was present and distributed in 96% of the training sessions.

On Deworming Day most schools (83%) had all the required drugs, reporting forms, and tablet poles, which points to a good supply chain for these key materials (Figure 4). Unfortunately, 37% of schools did not use the reporting forms to record treatment.

Figure 4: Availability of all key materials across the implementation cascade⁶



From post-deworming interviews with head teachers, 90% indicated sufficiency of the initial drugs availed. All three schools reporting a deficiency had run short of praziquantel, but had reached out to the LGA NTD Coordinator. Of the 83% of schools with a drug surplus, 52% planned for a mop-up before returning drugs to the LGA, 40% of schools returned their surplus immediately, and 8% planned to share with other schools or distribute to teachers.

4.3.1 Community sensitization materials

Before training began, 96% of training sessions had posters available, but only 70% distributed them at the end of the session. On Deworming Day, 97% of schools had posters available, while 93% had the posters pinned, with head teachers reporting an average of 2 posters per school.

⁶ All key materials include: drugs, tablet poles, and reporting forms (treatment registers and school summary form).

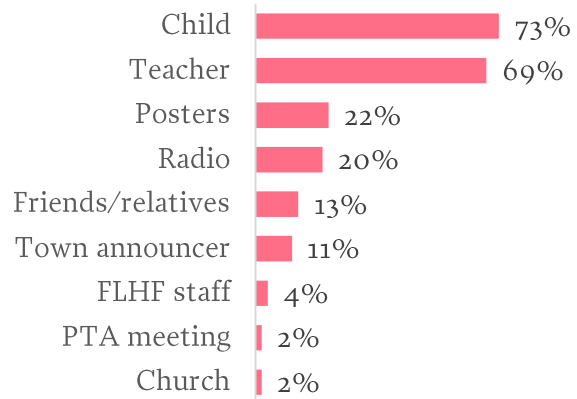
4.4 Community Sensitization

Community sensitization prior to Deworming Day is an evidence-supported factor critical for MDA success. On Deworming Day, monitors held interviews with 73 parents (60 of enrolled children and 13 of non-enrolled children) to gauge their awareness of MDA, as well as their sources of MDA information.

4.4.1 Implementation of community sensitization

Only 63% of head teachers reported sending someone from the school to mobilize children in the community for the MDA. The majority of head teachers indicated that this was either a student (84%) or a teacher (68%); consequently, children (73%) and teachers (69%) were also the most common sources of Deworming Day information cited by parents (Figure 5).

Figure 5: Sources of Deworming Day information cited by parents



4.4.2 Community knowledge

Prior to Deworming Day, 88% of parents, 93% of enrolled children and 62% of the non-enrolled children, were aware of Deworming Day. More parents of enrolled children had taken their children for deworming in the past, compared to those of non-enrolled children (53% vs 14%).

Knowledge of other key deworming aspects was generally low among parents aware of Deworming Day. Only 70% of the parents of enrolled and 14% of non-enrolled children were aware of the target age-group for schistosomiasis. Respectively, 59% of enrolled and 20% of non-enrolled were aware of the STH age target. Forty-six percent of parents were not aware of the type of worms being treated. Additionally, 96% of parents aware of Deworming Day indicated receiving messages encouraging them to feed their children before deworming, with 89% of these parents reporting that they complied.

At the end of these interviews, 93% of all of the parents that were aware of Deworming Day indicated that they would be sending their children for deworming (100% of parents of enrolled and 43% of parents of non-enrolled).

As part of the survey, parents were asked for their preferred methods of receiving future communication on deworming. Radio (92%), teachers (55%) and poster (38%) emerged as top preferences. Radio (100%) and posters (80%) were preferred sources of information among parents of non-enrolled children. While these methods were used during this round, they each reached a fifth the parents of the non-enrolled children (Figure 5).

4.5 Deworming Day

Thirty schools were monitored on Deworming Day, of which 80% were primary level, 13% were junior level, and 7% included both levels. By school type, 53% were public while 47% were private. The purpose of the visit was to assess MDA procedures and interview the deworming team to assess their knowledge and capability to deliver the MDA.

4.5.1 Preparedness for Deworming Day

All (100%) head teachers interviewed had made plans to deworm, and all (100%) head teachers reported that either they or a teacher from the school had attended training within a month of the MDA, which contrasts the 67% school representation during the teacher training.⁷

Monitor observations of school infrastructure revealed that 40% of schools lacked hand washing facilities and 10% of schools didn't have a toilet facility.

4.5.2 Deworming Day Delivery

Of the 30 schools that were originally sampled for Deworming Day monitoring, 20 schools were replaced due to various challenges. Nine schools did not deworm as planned, two schools did not exist, four schools were deworming at a later date, three schools could not be accessed for monitoring, and two schools could not be found.

All ten of the non-replaced schools and all twenty of the replacements conducted deworming on the designated day. Of the 43 schools that were found or could be accessed, only 30 schools conducted deworming on the designated date, for a rate of only 70% that conducted deworming. This was down from 83% of schools in Ogun that conducted deworming in Round 1 of 2019.

4.5.2.1 Adherence to MDA procedures

Adherence to drug administration protocol was generally high (at least 70% of correct administration steps). All schools gave the correct dosage of the mebendazole tablet to children and all teachers requested children to chew the tablet (Table 6). However, low adherence (at most 70%) was noted for pre-deworming preparations as well as recording treatment. Instances of children being availed drugs without asking if they were under medication were noted in 27% of schools, likely related to the 5% of teachers stating that they would treat sick children in post-training interviews.

Table 6: MDA procedures observed by monitors during drug administration (n=30)

MDA practice	Percent
Pre-deworming preparations	
Health education messages were given to children prior to treatment	70%

⁷ The inconsistency is likely due to some schools sending teachers to mop-up trainings, which are not monitored, and also due to self-reporting.

Teachers ensured children washed their hands prior to treatment	27%
Drug Administration	
Teachers who gave the correct dosage for mebendazole (1 tablet)	100%
Tablet pole was used to determine praziquantel dosage (n=28)	93%
Teacher asked child to chew the mebendazole tablet	92%
Spoilt tablets were properly disposed (n=17)	88%
Teacher asked if child was sick or under medication before administering medicine	73%
Recording treatment	
The teacher had transferred the names from the class register to treatment register prior to the deworming exercise	70%
All sections of the treatment register were filled out	67%
The treatment register was used to record treatment	67%

Out of the 60% of schools that had handwashing facilities, only 45% ensured that children had washed their hands before deworming.

4.5.2.2 Management of side effects and referrals

Two occurrences of side effects were observed by monitors. These were related to nausea and abdominal discomfort. Both incidences were effectively handled.

4.5.3 Attendance Rate

All eligible children were treated in 80% of schools. Refusal by some parents (50%) or fear of the drugs (33%) were the main reasons as to why some children were not dewormed. There were no reports of children being forced to swallow drugs. Ninety-two percent (92%) of schools also took steps towards planning for absentees for treatment when they returned by recording their names on the treatment register.

While 70% of head teachers indicated that they had made plans to deworm non-enrolled children on Deworming Day, only 10% of the schools dewormed non-enrolled children, a statistic lower than the (13%) noted in the last round of deworming. Of the head teachers indicating that they did not have a plan to deworm non-enrolled children, 38% indicated that school management was against treating them, non-enrolled children would come on their own (25%), or non-enrolled children were not informed (13%).

5.0 Recommendations

5.1 What worked well

1. Post-training knowledge of key aspects for the topics on worms and the target population, drugs and drug administration was high (at least 90%). Additionally,

the key topic on recording forms was highly covered, with the key reporting forms covered in at least 90% of trainings

2. Overall awareness of Deworming Day and the willingness to send children to school for deworming was high among enrolled parents at 93% and 96% respectively, which justify using the same means of reaching parents, particularly the cost effective options of children and teachers.
3. Key steps during drug administration and recording of treatments were generally well performed, as exemplified in the scores for provision of the correct drug dosage (100% for mebendazole and 93% for praziquantel). Side effects were few, and all cases handled appropriately. In addition, there were no reports of children being forced to swallow drugs in this round, an important improvement over past rounds.
4. The supply chain was remarkably well executed, culminating in 83% schools having the key required materials (reporting forms, tablet poles and drugs) on Deworming Day. The supply chain for drugs was most impressive, with availability noted at all cascade stages.

5.2 What can improve

1. Overall attendance of the teacher training can be improved, as only 67% of teachers attended, with a similar school representativeness (67%). Additionally, 25% of participants arrived after training started. Checking the communication from the program to schools, as well as encouraging schools to promptly communicate to teachers to make necessary prior preparations to attend the teacher training is one suggested step towards improving this low statistic.
2. The following training messages need to be emphasized, and correctly conveyed:
 - a. Complete coverage of the message on STH prevention, as this was limited to only 38% of training sessions.
 - b. Messages regarding target populations, as three trainers provided incorrect information on the target population; two indicating that the program only targeted enrolled children.
 - c. The treatment registers must be completed as they are the source document for the school summary forms, as these were used in only 63% of the schools.
 - d. Five percent of trainees indicated that they would deworm sick children in post-training interviews, so this aspect of the target group should be emphasized.
 - e. Training could also help address the issue of providing drugs without seeking to understand if children are under medication, as noted in 27% of schools.
3. On Deworming Day, 20 of the 30 originally sampled schools for monitoring (67%) had to be replaced, and only 70% of all the schools that were found or could be monitored were conducting deworming. Nine schools did not deworm

at all, four schools planned to deworm on a later date, and seven schools were not found or could not be monitored. The program should look closely at these results to ensure that planned schools are deworming on the designated date, and to have a better understanding of schools locations and existence ahead of monitoring.

4. It has been consistently difficult to interview parents at observed schools on Deworming Day; parents were only interviewed at 33% of schools in Ogun this round. The program and MLE teams should determine if better sensitization can encourage parents to come to the school or if this portion of the monitoring should be reviewed.
5. Community sensitization of non-enrolled children was poor. The key teacher role in mobilizing non-enrolled children was only covered in 59% of training sessions. Only 10% of schools dewormed non-enrolled children. This calls for advocacy at all levels, from training to deworming, to ensure the inclusion of non-enrolled children for deworming.