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REACH
RESOURCES
FOR CHILD
HEALTH

Urban EPI in Nigeria: Planning for Lagos City

February 3 - 18, 1992



**Urban EPI in Nigeria:
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Acronyms

| | |
|---------------|---|
| CCCD | Combating Childhood Communicable Diseases |
| CDC | Centers for Disease Control |
| CDD | Control of Diarrheal Diseases |
| CEIS | Computerized EPI Information System |
| DPT | Diphtheria/Pertussis/Tetanus Toxoid |
| EPI | Expanded Program on Immunization |
| FMOH | Federal Ministry of Health |
| IEC | Information, Education, and Communication |
| JSI | John Snow, Inc. |
| LGA | Local Government Area |
| NGO | Non-governmental Organization |
| NNT | Neonatal Tetanus |
| PHC | Primary Health Care |
| REACH | Resources for Child Health Project |
| SMOH | State Ministry of Health |
| TAACS | Technical Advisor in AIDS and Child Survival |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid |
| UCI | Universal Childhood Immunization |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| VHW | Volunteer Health Worker |

I. Executive Summary

Two REACH advisors visited Nigeria from February 3-18, 1992, as follow-up to an earlier REACH mission in September 1991, which identified the potential for an urban immunization program within the national Expanded Program on Immunization (EPI). This second visit was made once the identified urban EPI effort had been accepted by the Federal Ministry of Health (FMOH) and USAID/Lagos. The objectives of the second visit were to:

- Determine urban-specific EPI needs for Nigeria;
- Determine with the government and other donors which locations should be scheduled for intensified urban EPI efforts; and
- Prepare an initial workplan for an 18-month urban EPI activity which will be supported technically and financially by USAID/Nigeria and REACH.

Prior to the visit reported here, Lagos City was selected by the FMOH as the location for the urban EPI project. While there was discussion of limiting involvement to only one Local Government Area (LGA) in the city, it was agreed with the Nigerian Government that this limited approach would neither allow for measurable results nor be epidemiologically sound. In a densely populated urban area such as Lagos, the transmission of vaccine-preventable diseases (i.e., measles) is rapid, severe and not specific to any one area. Therefore, to be effective, disease control efforts must be placed in the larger urban context. On this basis, all 12 urban LGAs of Lagos State were targeted for what will be called the "National Urban EPI Project."

During their visit, the REACH advisors worked with an EPI team from the FMOH and the Lagos State Ministry of Health (SMOH). Information was collected through (1) a formal survey of the LGAs which constitute Lagos City, (2) two workshops with EPI managers and LGA health officers, (3) individual interviews with government, private sector and donor representatives, and (4) site visits to LGAs and immunization contact points.

REACH advisors and government EPI teams used the findings from these activities to develop an initial workplan for urban EPI activities at Federal, State, and LGA levels. Besides proposing activities with the government agencies that are traditionally involved in the EPI, the workplan also proposes the increased involvement of private sector health providers (for-profit and not-for-profit) and other donors.

REACH is using the findings of this trip to develop a more complete proposal for the urban EPI effort. The six priority activities that will be included in this proposal are as follows:

1. **Decentralized Planning:** USAID/Lagos and REACH propose to provide support to the 12 LGAs for the development of detailed LGA plans of action to improve immunization coverage and disease control. LGA planning will be done during a workshop or series of workshops for EPI managers.
2. **Implementation of Immunization Services:** Implementation of the LGA workplans will be the responsibility of each LGA, with support and guidance from the SMOH and the FMOH. REACH proposes to provide an Urban EPI Coordinator who will be assigned to the project full-time. The Coordinator will provide technical input at each level of the government. Overall implementation of the workplans will be monitored at the monthly meetings of the state EPI committee. The REACH

Coordinator will ensure participation of the private sector in these meetings. In addition, the role of the private sector in providing immunization services will be expanded with REACH assistance.

3. **Supervision:** Data gathered during this visit indicates that supervision must be improved if urban EPI efforts are to succeed. The CCCD workplan already envisages a number of workshops focusing on supervisory skills. These will be followed up by on-the-job training in supervisory techniques in priority LGAs by the REACH Coordinator. Results of supervisory visits should also be discussed at the monthly state committee meeting.
4. **EPI Information System:** The collection and analysis of data on vaccination activities, vaccine supply and logistics, and morbidity and mortality from target diseases will be improved, and regular feedback will be provided to the LGAs on progress towards their stated targets. Improving the collection and use of information is part of the CCCD workplan and REACH will assist with this task. Additionally, REACH will install the CEIS computer software package at the State and possibly the Federal levels and provide appropriate training to EPI managers at each level in the use of CEIS data.
5. **Communications:** IEC activities will be developed to meet the specific needs of the heterogeneous urban population, especially the highest risk groups. As part of this effort, REACH will conduct an assessment of IEC needs paying particular attention to EPI users' needs.
6. **Evaluation/Operations Research:** The Urban EPI effort will be evaluated after approximately 16 months of operation. Evaluation criteria will focus on indicators of EPI service coverage although the period of implementation being evaluated is short. Activities include disease surveillance, coverage surveys, and use of quality of service indicators.
7. **Dissemination of Findings:** The Urban EPI project in Lagos will serve as a model for other parts of Nigeria and for planners from other countries who are interested in focusing additional attention on immunization and primary health care services in fast-growing cities. A national workshop to discuss project activities and findings is proposed at the end of the 16 month project period. An international meeting on Urban EPI may also be sponsored by USAID/Lagos and REACH in partnership with other donors, using the Lagos project as a model.

A series of follow-up actions are required to begin USAID/REACH support to the National Urban EPI Project in Nigeria, including:

- 1) the completion of a proposal and a memorandum of understanding for the Lagos project by USAID/Lagos and REACH;
- 2) review and acceptance of the proposal and memorandum by AID/Washington, the Nigerian FMOH, the Lagos SMOH, and USAID/Lagos;
- 3) the recruitment and hiring of a full-time REACH Coordinator who will work in collaboration with the CCCD Lagos State Epidemiologist (see Appendix 1, Job Description).

II. Introduction

A. Background

As follow-up to a REACH mission to Lagos in September 1991, a second visit to Nigeria was undertaken from February 3-18, 1992, by REACH Technical Officer, Ken Olivola and REACH Consultant, Dr. Felicity Cutts.

The purpose of the earlier assessment visit in September was to determine the potential for an urban demonstration project within the national Expanded Program on Immunization (EPI). It was clear from the initial visit that there was a need to improve immunization services, especially in Lagos City, and that the FMOH and USAID/Lagos would be interested in pursuing the development of a REACH-supported demonstration effort (see "Urban EPI in Nigeria: A Preliminary Assessment", September 16-27, 1991). While REACH has substantial experience in urban EPI programs around the world, a second programming visit was required to address the specific needs of Nigeria and to define with government and USAID/Lagos the scope of the proposed demonstration project.

B. Purpose

The second visit, reported here, was undertaken with the understanding that the Federal Ministry of Health (FMOH) and USAID/Nigeria were in support of the urban EPI demonstration project proposed by REACH.

The REACH team focused on three primary objectives for their visit:

- Determine urban-specific EPI needs for Nigeria;
- Determine with government and other donors which city(s) should be scheduled for intensified urban EPI efforts; and
- Prepare workplans for urban EPI activities for a period of 18 months.

III. Trip Activities

Throughout their mission, the REACH team worked closely with a government EPI team, consisting of representatives of the FMOH, EPI Division, and the Lagos State Ministry of Health (SMOH). With this team and representatives from non-governmental and donor agencies, they identified specific successes in the existing effort to immunize children in Lagos City, as well as constraints to improved immunization coverage and disease control.

Information was collected through:

1. **LGA Survey.** A survey instrument was developed to assess management at the LGA level and it was used in interviews in 6 of the 12 urban LGAs which constitute Lagos City (see Appendix 2). Persons interviewed included the LGA Medical Officer of Health, Chief Nursing Officer, and EPI Manager. In each LGA, health facilities were also visited, persons responsible for EPI were interviewed, and the cold chain was observed. The SMOH EPI Manager was interviewed and her reports from supervisory visits to LGAs were reviewed.

2. **Meetings.** Two meetings were held to collect information about the EPI at LGA, SMOH and FMOH levels and to begin the planning process. The first such meeting (focus group format) with LGA EPI managers aided in identifying successes and constraints in the Lagos EPI. The second meeting included the LGA EPI Managers, the 12 Medical Officers of Health, representatives from the SMOH and FMOH and from other non-governmental organizations, including the Medical Association of Nigeria. The purpose of this meeting was to begin to build a consensus as to the need for a special EPI focus in Lagos City. The second meeting was opened by the Assistant Director, EPI/CDD/ARI (PHC). A summary of the September REACH visit and a review of the LGA EPI Managers' focus group session were made.
3. **Interviews.** Informal discussions were also held with FMOH personnel to determine the process of EPI management and interrelationships between the levels. A list of persons contacted during the visit can be found in Appendix 3.

The LGA survey and workshops proved to be very valuable for programming purposes. Findings from the survey and the two meetings are summarized below in Section IV. Findings and the meeting notes are presented in Appendix 4.

Together, the REACH Advisors, the FMOH EPI Team and the SMOH developed an initial workplan for urban EPI activities at Federal, State, and LGA levels; the workplan contemplates the involvement of government institutions as well as private sector EPI providers, NGOs, and other donors in Lagos. It is currently being further developed into a proposal for REACH assistance to the Government of Nigeria.

IV. Findings

A. Site Selection

After careful consideration of the needs and available resources, the government, USAID, CCCD, and REACH jointly decided to concentrate the initial urban EPI efforts in one city - Lagos.

There was discussion of limiting REACH involvement to only one LGA in the city. However, the REACH team, in discussions with the Nigerian government, agreed that this approach would not allow for measurable results. At the same time, focusing on only one small section of a densely populated urban area was felt to be epidemiologically inappropriate due to the rapid transmission and highly contagious nature of diseases such as measles. It would be unrealistic to limit a measles control intervention, for example, to only one area of a densely populated city since it simply will not work.

Lagos State consists of 15 LGAs; the decision was made to focus urban EPI work in 12 of these LGAs, or those that make up Lagos City.

It is important to stress a couple of points concerning which LGAs actually make up Lagos City. The team tentatively identified 12 LGAs, but it is not clear from the maps used if, in fact, all of the 12 LGAs actually are "urban". While they do border Lagos City, a few of the LGAs may only "touch" the city on the unpopulated lagoon. This needs to be confirmed. Additionally, a number of the identified LGAs are clearly not fully urban as they have significant rural land areas. A full assessment of each LGA will be required to finalize these, and other details. This will be the first step for LGA planning and implementation.

B. Project Name

It was agreed with the FMOH that the first urban EPI effort should have a measurable impact, while providing a learning experience from which other Nigerian cities can benefit. Based on this decision, REACH and the FMOH agreed to call the USAID/REACH-supported project the "National Urban EPI Project" Giving the project national status is expected to result in more rapid dissemination of lessons learned from Lagos City and their application in the near future to other urban areas in Nigeria.

C. Roles and Responsibilities

It was clear during the visit that each level of government (Federal, State, and LGA) has a distinct and important role to play in the EPI in Nigeria. The specific roles are defined as follows:

- FMOH: a) procure vaccines
b) provide policy and technical guidelines
c) monitor and evaluate the EPI
- SMOH: d) distribute supplies and equipment
e) support manpower development/training
f) provide technical support and supervision
- LGAs: g) implement PHC activities (EPI)
h) provide monthly information to SMOH

The FMOH has the overall responsibility for making EPI policy and ensuring that it is implemented at State and LGA levels. The SMOH supervises EPI activities within the state, distributes supplies and vaccines, and trains local EPI workers. The State also manages government hospitals and some health centers in urban areas. Finally, each LGA has its own EPI staff and is ultimately responsible for implementing the EPI at clinic level. The LGA also involves private sector EPI providers as well as non-governmental organizations in EPI implementation.

Given these important differences, specific and autonomous workplans for urban EPI at each level of government are necessary. In order to ensure an enduring urban EPI in Nigeria, it will be imperative that each participant in the urban EPI effort (government and non-government) have a clearly defined role to properly carry out their respective work. While workplan development was begun at the Federal and State levels (see Appendix 5) during this visit, more extensive work will be necessary to develop individual workplans for each of the three levels, especially for the LGAs.

D. EPI Service Delivery Strategies

Although general EPI service delivery strategies have been developed by the FMOH and the SMOH, individual LGAs have been able either to modify these strategies, or, in some cases, to actually develop their own. Within Lagos City, in fact, each LGA has its own distinct implementation strategy. In addition to providing service in fixed clinics on at least a weekly basis, all of the LGAs also use more than one of the following substrategies.

Outreach:

SMOH policy is for each health center to have 3 outreach sites, based on the State EPI Manager's experience and questions in the 1991 coverage survey showing distance and waiting times at clinics to be factors limiting uptake.

At the LGA level there appears to be excessive reliance on outreach work. In an urban setting such as Lagos City it is difficult to justify this costly strategy when real and potential vaccine sites are so readily available. Fixed sites are meant to immunize daily, but often this is not implemented. More attention to reinforcing fixed sites would make more sense than considering the expansion of outreach. In fact, closing down outreach in Lagos City ought to be considered.

"Out of hours" clinics:

During the rush in 1990 to successfully achieve Universal Childhood Immunization (UCI), the "out of hours" clinic strategy (both facility and non-facility-based) was used extensively. During that period there were funds to pay the excessive overtime costs to implement this strategy. Today, several LGAs continue to employ this strategy, but to varying degrees. Most do this during designated periods of time, i.e., 2-3 special days per month when the LGA organizes extra outreach (markets), evening and weekend clinics.

Blitz:

Each LGA chooses 3 months of the year to implement their Blitz strategy. Extra immunization sites are created, and vaccinators visit 3 days each month for 3 consecutive months.

E. Private Sector Providers

Half of all health care, and 20 percent of all measles vaccines in Lagos City are provided by the non-governmental sector (private and NGO). It is possible that the nongovernmental sector could provide even more vaccines. More information must be gathered to determine how to encourage the participation of this sector in the Lagos City EPI, and to ensure that they follow EPI norms.

F. Cold Chain/Logistics

The cold chain strategy is part of the overall approach to EPI. Usually a cold store is at the LGA level and vaccines are distributed or collected by each facility in cold boxes. This varies by LGA, e.g., Lagos Island takes cold boxes weekly to each facility; in Mushin each facility comes for vaccines on their immunization day and only has a vaccine carrier. It is unclear how well private immunization providers respect vaccine cold chain requirements. Currently there is no system to monitor and control the cold chain at all levels.

There was discussion in both workshops, as well as information gained from the survey and site visits, concerning vaccine supply, which appears to be a problem in some LGAs. At present, a "push" type system for vaccine supplies is used. Vaccine amounts are calculated and sent out by the State to the LGAs. When several LGAs expressed concern that they were not receiving enough vaccines, they were first advised to cut back on vaccine wastage.

This raised the issue of whether or not to open a vial of measles vaccine for only one child, and throw away the rest, or rather to not give any vaccine at all. Although Federal policy is to open a vial even if only for one child, this is still not clear at State and LGA levels. Vaccine supply issues must be addressed.

G. Community Mobilization

Many activities have been implemented to mobilize and involve the community at large in the EPI. Community mobilization efforts were particularly strong during the UCI effort. During this period, public enlightenment vans with loudspeaker systems were used to inform people that they must immunize their children. State health education teams went to communities, distributed pamphlets and gave talks. Many different mechanisms were developed and proved to be successful means for informing communities and NGOs. At present, some LGAs have begun to use VHWs and TBAs to inform and mobilize community members for immunization; however, use of NGOs and community groups for this purpose has generally been weak.

While overall acceptance of immunization is thought to be high (and actually is quite high when results of coverage surveys are studied), specific problems with the EPI, like high drop-out rates between DPT3 and measles, still persist. The drop-out problem should be addressed through a communications effort which includes:

1. A study of consumer beliefs and practices to determine why drop-out rates are high, and how to overcome this problem; additional benefits from a consumer assessment for improving the EPI in Lagos City might also include information on where families obtain immunizations, their perceptions of EPI services, etc.
2. Message development and audience targeting to better address problems of drop-out.
3. Production of communications media, as appropriate.

H. Defaulter Tracing

The ability to carry out defaulter tracing varies by LGA. State policy is to conduct tracing, but not all LGAs are able to for a variety of reasons, including difficulties due to population movements within and between LGAs, and outside Lagos. Also, lack of personnel to follow up with defaulters is a constraint. A sustainable system needs to be set to deal with this.

I. Coordination

The State EPI office is currently separate, and a considerable distance away from the rest of the SMOH. There are plans to move the State EPI into the Ikeja State headquarters with other health divisions. When the move does take place, the State EPI will be better able to coordinate with other PHC activities.

The State EPI Manager meets monthly with LGA EPI Managers to discuss progress of the EPI and to identify constraints. These meetings, while extremely useful, do not appear to lead to necessary follow-up in rectifying identified problems.

The LGA EPI committees meet the second Thursday of each month. Minutes are taken and filed. The format of these meetings is to discuss the previous month's activities and constraints. Members include:

- 1) LGA EPI Manager
- 2) Rotary
- 3) Inner Wheel (female Rotary)
- 4) Scouts and Guides
- 5) Red Cross
- 6) Ministries of Education, Youth sports and culture
- 7) Nigeria Medical Association (invited but does not attend)

The LGA EPI Committee has great potential as a coordinating body within respective LGAs, including involving non-governmental players in the EPI. The general impression is that many of the LGAs have not fully exploited these committees to improve the EPI. This is especially true in terms of involving private sector providers.

All LGAs have PHC coordinators (usually the Medical Officers of Health) and EPI Managers.

J. EPI Planning and Data Needs

EPI Planning is decentralized but follows national policies. The FMOH sets policy, and the SMOH (using Federal and State data) sets targets for EPI in Lagos State. However, the lack of current census data for Lagos City makes it extremely difficult to set targets and, consequently, to monitor project progress. As a result, this is not routinely done.

The 1991 census will certainly be most useful when results are available (expected in April 1992), but there is reason to believe that urban populations will be undercounted. This ought to be discussed further with the federal census office. In any case, it is essential that the recent census be used to recalculate target figures for the EPI in Lagos City. This should be done at the smallest area possible which coincides with EPI catchment areas. Ideally, this could be done at ward level.

There is little targeting of activities to deprived areas, though LGAs seem to know which areas are worst off in terms of crowding, low literacy, poverty, and lack of physical infrastructure. In the second workshop, the EPI managers did not seem to fully understand the concept of targeting. In workshop discussions they did not see the need to target activities to deprived neighborhoods, nor did they understand what a "deprived" neighborhood would be. The definition of "deprived" or "high risk" neighborhoods should be developed with the LGA EPI Managers, as well as other FMOH, SMOH, and LGA personnel.

The LGA EPI managers do not see planning (or the lack of it) as a problem, and there is some confusion as to the degree of detail which an effective plan would include. LGA EPI plans are currently approved by the LGA Chairman, whose decision is based on broader LGA administrative considerations rather than technical EPI needs.

K. EPI Monitoring and Supervision

Improving supervision at all levels of the EPI would have a significant impact on the project. The FMOH currently makes few supervision visits in Lagos City or to Lagos State. The SMOH meets with LGA EPI Managers, but is not able to travel out to the individual LGAs and service delivery points regularly because of limited staff. LGA staff are equally overburdened and are not able to adequately monitor and supervise EPI activities in their LGAs. At no level are private sector EPI providers monitored nor supported.

When supervision does take place, EPI checklists are not used. This simple tool could do a great deal to improve supervision if the checklists were used, analyzed, and discussed.

L. Management Training

Finally, it was discovered that none of the LGA EPI Managers have had the standard EPI Managers training. This ought to be a high priority activity at the early stages of the urban EPI effort for Lagos City.

V. Recommendations for Strengthening Immunization Services in Urban Nigeria (focus on Lagos City)

The review of constraints and discussion of potential solutions at the planning and review meeting on Feb 13th, was very comprehensive and generated an exhaustive list of potential activities that could be carried out under the project proposed by REACH. While all activities will ideally be implemented over the course of the next year or two, certain activities should be signalled for greatest priority.

Recommendations are as follows:

1. REACH should recruit a full-time Nigerian Urban EPI Coordinator, who will work in collaboration with the CCCD state epidemiologist (see Appendix 1, Job Description). REACH Technical Officers stationed in Washington will make periodic visits to Nigeria for the project. Duties of the REACH/Nigeria Coordinator will be to ensure that the priority activities are implemented, and to conduct the necessary training, supervision and monitoring of the project to achieve this.
2. Priority activities should include the following:
 - a. LGA Planning: Develop a detailed EPI plan of action with each LGA. This could be done during a workshop for EPI managers within each LGA. Plans would include the preparation of:
 - 1) maps of each LGA indicating public and private health facilities (distinguishing those that provide immunization from those that do not), "at risk" neighborhoods, market places, churches and mosques;
 - 2) explicit targets based on updated population data from the 1991 census;
 - 3) activities to be conducted at static and outreach immunization sites throughout the year, indicating who is responsible for each;
 - 4) activities to be conducted at community level and their timing, e.g., door-to-door mobilization would appear to be most appropriate during the July/August school holidays, which is also the trough of measles incidence and hence the best time to prevent an accumulation of susceptibles to measles. A mobilization plan should be drawn up stating which NGOs, community groups, volunteer health workers and TBAs will be involved, who will contact them, when they will conduct activities, what support and training they need and how this will be conducted etc;
 - 5) annual budgets, distinguishing clearly between items to include in the regular budgets and items to be included in imprests;
 - 6) vaccine requirements and storage sites;
 - 7) supervisory schedules;

- 8) monitoring activities, e.g., charting the number of doses of each vaccine administered each month compared to the estimated target population of infants and women of childbearing age;
- 9) extra activities necessary to improve neonatal tetanus (NNT) control, e.g., working with TBAs, school-based vaccination;
- 10) the expected contribution of the private sector in each LGA, and how that contribution will be obtained.

b. Implementation of Workplans:

Implementation will be the responsibility of the individual LGAs, with technical support from the REACH/Nigeria Coordinator and the SMOH and FMOH, as required. Implementation should be monitored at the monthly meeting of the state EPI committee. Efforts should be taken by the Project Coordinator to ensure participation of the private sector in these meetings. In addition, the role of the private sector in providing immunization services should be expanded with REACH assistance.

c. Supervision:

Supervision should be improved. The CCCD workplan already envisages the conduct of workshops on supervisory skills for EPI. These should be followed up by on-the-job training in priority LGAs by the REACH Coordinator. Results of supervisory visits should also be discussed at the monthly state committee meeting. The major objectives of improving supervision are to:

- 1) ensure daily vaccination at each static immunization site;
- 2) improve patient flow at static sites and reduce waiting times;
- 3) improve individual face-to-face information about return appointments and the need to complete the immunization series for both infants and women of childbearing age;
- 4) improve vaccine stock control and ensure continuous supplies of vaccines;
- 5) determine the effectiveness of outreach by monitoring attendance and quality of vaccination practices at outreach sessions; and
- 6) supervision of LGAs to assess the functioning of the PHC management committee and district development committees, and to liaise with State and Federal levels to provide any support required.

d. EPI Information Systems:

Data relating to vaccination activities, vaccine supply and logistics, and target disease morbidity and mortality should be improved, and regular feedback provided to the

LGAs on progress. This is part of the CCCD workplan and may be the main responsibility of the CCCD epidemiologist, but the REACH/Nigeria Coordinator should assist. Included in this will be REACH's installation of the CEIS computer software package as well as appropriate support, as agreed by CCCD in Lagos.

e. **Communications:**

IEC activities are to be developed and implemented which meet the specific needs of the heterogeneous urban population -- especially the groups at highest risk. REACH will conduct an EPI consumer profile assessment.

f. **Evaluation/Operations research:**

The demonstration project proposed by REACH is intended to generate important lessons that can be used by planners to extend the urban immunization focus to other cities in Nigeria. As such, project results should be monitored closely during implementation, with a pre-post evaluation design used to measure results in individual LGAs and overall. If we hope to take full advantage of this opportunity to develop and test alternative service delivery, communications, and planning approaches that are appropriate for urban areas, then the systematic measurement of project results will be even more important.

Proposed evaluation activities over the life of the project will include:

- 1) A formal assessment of the quality of vaccination practices (including maintenance of the cold chain, vaccination technique, patient education), missed immunization opportunities, and standards of case management for diarrhea, malaria and acute respiratory infection. This assessment should be conducted on a random sample of health facilities in each LGA, using the CCCD health facility assessment protocol. This protocol can be considered an extension of supervision using checklists, and should eventually become a routine part of monitoring immunization activities in Lagos. It has already been used in other States of Nigeria.
- 2) Pre- and post-implementation surveys of immunization coverage and/or measles and neonatal tetanus incidence and mortality rates: This would provide information on baseline levels of target diseases and community-based information on the age-distribution of measles cases and deaths, which will show the relative importance of measles in infants under 9 months of age. Potentially the sample could be taken in a way that would provide information on immunization coverage in the priority LGAs as well as aggregate data on target diseases in the State.

3. **Relationship of REACH and CCCD**

For operations research, and possibly for the workshop to develop LGA plans of action, the assistance of personnel from the Division of Immunization, Centers for Disease Control, Atlanta, GA may be available. CCCD should pursue discussions to determine their availability. If appropriate, the Division of Immunization may be able to provide useful support for operations research activities under the USAID/Lagos and REACH Project in Lagos City.

VI. Follow-Up Actions

The following actions will be undertaken to begin a National Urban EPI in Lagos City:

1. Draft Proposal and Memorandum of Understanding will be sent from REACH to USAID/Nigeria for circulation and comments and then returned to REACH to be put into final form.
2. Final Project Proposal and Memorandum of Understanding will be signed by REACH and sent to USAID/Nigeria for signatures by USAID/Nigeria and Government at Federal, State and LGA levels. CDC's Division of Immunization should be encouraged to participate at this time.
3. When the Memorandum of Understanding is signed, CCCD will assist REACH in recruiting a full-time REACH/Nigeria Coordinator and when he/she is in place, REACH will send one EPI staff or consultant to Lagos to orient and assist the full-time advisor. CDC's Division of Immunization may wish to participate in this orientation visit.
4. The project will begin by finalizing the Lagos City EPI workplan at Federal, State, and LGA levels, while simultaneously beginning identified project activities (see Appendix 5).

Appendix 1

Job Description for Immediate Opening for Field-based Urban EPI Specialist

for assignment to

Lagos State EPI

for

USAID's "Resources for Child Health" (REACH) Project

STATEMENT OF WORK

Job Title: REACH/Nigeria Coordinator

I. Background

USAID/Nigeria manages a \$100 million development assistance program intended to help the people and government of Nigeria improve their social and economic well-being.

Among other activities, the program assists the Nigerian Federal Ministry of Health in child survival programs, including activities for strengthening the Expanded Program on Immunization.

The overall objective is to decrease morbidity and mortality of infants and children under the age of 5 years. Nigeria has made great strides in its development of the EPI with assistance from CCCD, and other donors such as UNICEF, WHO, and Rotary. However, a September 1991 visit by REACH in Nigeria began to link the decline of immunization rates with the country's rapid levels of urbanization.

The findings about Lagos and its EPI coverage were quite surprising when closely examined. Although assumptions were that the largest and most cosmopolitan urban center, and the city with the greatest concentration of health facilities, would logically have the best health indicators in the nation, findings from the 1991 coverage survey were completely contradictory. Lagos was found to have access to immunization services equal to, but no greater than all other areas of the country. However, the drop-out rates between DPT3 and measles are the worst among all other states in the country. Measles coverage in Lagos is lower than the national average and lower than a majority of states.

As the focus of EPI in the 1990's in Nigeria, as elsewhere, is turning to specific disease reduction targets, it becomes increasingly important to ensure that susceptible pockets do not persist in crowded urban environments. Despite evidence of declining measles incidence, the potential for explosive epidemics of measles in Lagos -- and presumably in other urban areas of Nigeria -- remains high.

Measles control, as well as the other EPI diseases, in an urbanizing environment will require a special focus within the existing EPI in Nigeria. Infants must be reached as soon as they lose maternal antibodies and become susceptible at nine months of age. Due to earlier age of infection, intensity of exposure, and higher prevalence of malnutrition, higher and earlier immunization coverage will be needed in urban areas

than in rural areas to more effectively reduce childhood mortality due to measles.

WHO, UNICEF and AID have all recently identified the need to improve EPI and PHC in peri-urban squatter and slum areas. Just as EPI has played a leadership role in the development and extension of PHC throughout Nigeria, it is now appropriate for the maturing EPI to lead the way to improved urban health by bringing PHC into the cities.

Urban-specific strategies which respond to some of the unique opportunities and specific challenges found only in cities are necessary. These may include:

- 1) microplanning of strategies
- 2) individual city EPI plans
- 3) developing assessment tools for EPI
- 4) gearing up social mobilization in cities
- 5) role for the private sector
- 6) reducing missed opportunities
- 7) inter-sectoral aspects of urban EPI
- 8) eventual integration of health services in cities.

As a result of these findings and based on the follow up recommendations, the Government of Nigeria, with USAID/REACH assistance, has agreed to pursue an intensive effort in its EPI in the country's cities.

The focus of an urban EPI effort will be to:

a) Improve the EPI in Nigerian Cities

In light of declining EPI coverage and potential for increasing disease incidence, a special effort will be made through the Federal Ministry of Health's EPI to improve overall EPI performance in Nigerian cities. This will include assessing overall quantity and quality of services in both the public and private sectors.

b) Launch Specific Urban Activities in Lagos City

Although the project is intended to benefit all urban centers in the country (representing about one-third of the national population), initial efforts will concentrate on Lagos City, and will be implemented through the Lagos State Ministry of Health.

c) Implement Activities Through the LGA in Both the Public and Private Sectors

Of the 15 LGAs which make Lagos State, there are 12 (Lagos Island, Eti-Osa, Lagos Mainland, Mushin, Surelere, Somolu, Isolo-Oshidi, Ikeja, Alimosho, Ojo, Ikorodu, and Agege) LGAs which comprise "Lagos City". It is with these 12 LGAs that activities will be implemented.

d) Specific Activities

Specific activities will include, but not be limited to: (1) developing actions plans for LGAs on how to improve immunization, (2) monitoring and supervising activities with each LGA, the SMOH, and the FMOH, (3) expanding the role of the private sector in immunization activities, (4) improving data relating to vaccination activities, (5) undertaking information/education/communication (IEC) activities at all levels, and (6) assisting with operations research activities.

II. Basic Function

The incumbent will be a recognized expert in Nigeria who has performed a wide range of consultative, advisory, monitoring, information gathering, and evaluation services of broad scope and complexity in the primary health field, with particular strengths in immunization, and/or has done a consider amount of community development work in urban settings. The incumbent will have sufficient multi-sectorial experience and professional training experience as a public health and/or community development program specialist to assist REACH to implement the USAID funded urban EPI project in Nigeria. More specifically, the incumbent will properly conduct EPI programing and community development-type activities in Lagos State as directed by the REACH project, in collaboration with CCCD in Nigeria.

III. Scope of Work

The incumbent's duties will include four performance elements, listed below, for which the incumbent will provide REACH with the following services, material, and/or end product.

A. EPI Planning

Assist REACH in the detailed planning, budgeting and implementation of EPI activities in Lagos State. This will require a multi-sectorial perspective and keen assessment of the capacity of both the public and private sectors at the Federal/State/LGA to adequately implement activities prescribed in the annual work plans, making adjustments to the work plan according to the level of effort available at the Federal/State/LGA. Experience in working with a wide range of persons from high level government officials, and medical association leaders, to primary health committee members is essential.

B. Project Implementation

Assist REACH in the implementation of numerous planned activities for the development of the EPI in the 12 LGAs of Lagos State which make "Lagos City". Primary support strategies will include, but not be limited to: program assessment and planning at multiple levels, implementation of workplans with both the public and private sectors, supervision and monitoring of activities at State and LGA levels, EPI surveillance and data gathering/processing, IEC, and operations research. The incumbent will have a demonstrated full range knowledge and experience in EPI as well as the primary support strategies. Experience in use of computers (word processing, spreadsheets, database, and graphics) is required.

C. Monitoring and Evaluation

Collaborate with federal, state, and local leaders in monitoring the progress of EPI activities as well as providing necessary supervision and training as a result of the monitoring project. The incumbent will possess the necessary analytical capability to determine trends in project performance and be able to describe clearly and cogently (verbally and in writing) what future impact the performance trends may have on the Project achieving its stated objectives. Computer assistance (as stated above) is essential.

D. Special Studies/Operations Research

The chosen candidate will have expertise in the methodological design and implementation of special studies and operations research projects.

For example, the incumbent will be able to direct surveys such as the World Health Organization standard cluster surveys to determine immunization coverage of children by age, antigen, and location, using computer software analysis results. Moreover, the preferred candidate will be able to evaluate trends from data analysis and make recommendations to REACH and Federal/State/LGA officials regarding use of human and financial resources to correct identified problem areas. Experience in computer assisted analysis is requisite.

E. Experience and Skills Working in Urban Environments

The ideal candidate will have experience and training in the urban environment, and will know how to adapt those skills to the on-going national EPI effort. Specifically the candidate will be perceptive to the multi-sectoral needs of working in cities, and especially skilled at understanding the needs and working with the urban at-risk groups for the EPI. Training and experience in community development work and/or urban development are highly desirable.

IV. Relationships and Responsibilities

The preferred candidate will be indigenous to Lagos State, having his/her residence in the capital city.

The incumbent will work closely with project personnel, particularly government personnel at Federal, State, and LGA levels, the CCCD Lagos State Epidemiologist, and REACH staff.

The incumbent will be expected to cultivate and maintain a cordial and professional working relationship with Federal, State, and LGA officials, professional associations, and other donor agencies.

IV. Reporting

Oral reports will be made to the CCCD Lagos State Epidemiologist and to REACH/Washington as appropriate or requested. Monthly written reports will be required within seven days following a reporting period. Special reports will be prepared as requested.

QUALIFICATIONS/EXPERIENCE

1. College Degree in Medicine, Nursing, Public Health (Bsc, HND or OND), Urban Planning, Community Development. Masters Degree in Public Health preferred.
2. Sound knowledge of Lotus 123, D-base, Word Perfect, Harvard Graphics, and related software.
3. 5-10 years substantive field-based experience in epidemiology, public health, and urban program implementation in EPI, training, and research.
4. Excellent writing and communication skills (sample of work).

SALARY AND BENEFITS: Generous package commensurate with experience and education.

Address letter of interest with complete curriculum vitae and three (3) recent letters of recommendation to:

Personnel Officer
American Embassy
2, Eleke Crescent
P.O. Box 544
Victoria Island, Lagos

Appendix 2

Summary of the LGA EPI Survey
Interview with LGA Management Team

A. Summary of results of the interview with LGA management team:

- 1) Geography/Ecological Characteristics
 - : updated maps - some available
 - : most boundaries clearly defined
 - : health facilities (public and private) generally known
 - : market places generally indicated
 - : deprived neighborhoods generally indicated
- 2) Population Size and Distribution
 - : census results (1992 due in March/April 1992)
 - : some migration patterns known
- 3) Communications
 - : generally ok although few phones
 - : rainy season not a major factor
- 4) Transport
 - : EPI must share with other LGA activities (non-health)
 - : for mobilization limited availability
 - : public transport generally available
 - : ease of transport for mothers and children unclear
- 5) Personnel
 - : working in EPI adequate for government; unknown in private
 - : working in health education/mobilization limited
 - : TBAs and volunteer health workers generally available
- 6) Continuing Education
 - : EPI logistics/management needed
 - : EPI techniques needed
 - : supervision skills upgraded
 - : monitoring/evaluation needed
 - : community mobilization needed
 - : drivers and maintenance workshops at LGA or private shops
- 7) Support Systems
 - : guidelines not always clear
 - : in-service training rarely available
 - : problem-solving localized
- 8) Vaccine Supplies and Vaccination Strategies
 - : some shortages at LGA level
 - : some shortages at health facility level
 - : generally adequate for daily vaccination
 - : unclear for new policies (TT, Polio 0).
 - : method of estimation by state (not LGA)
- 9) Planning and Budgeting Systems
 - : choice of strategies left to LGA
 - : numeric targets for vaccination activities not used
 - : flexibility of finance at LGA
 - : LGA legislatures decide

- 10) Evaluation
 - : coverage - routine done monthly, surveys rarely used
 - : contribution of outreach vs static sites not evaluated
 - : quality of immunization practices not evaluated
 - : missed opportunities not evaluated
- 11) Facilities
 - : target disease morbidity and mortality tracked
 - : timely analysis and feedback weak
- 12) Collaborating Groups
 - : private sector provides some EPI, but not systematic
 - : NGOs some EPI, but not systematic
 - : community groups (scouts, guides, Rotary, Red Cross, others)
- 13) Coordination
 - : all potential collaborating groups - occasional
 - : PHC committees functional - varies by LGA (esp. new LGAs)
 - : ability to act on decisions taken at meetings not clear
- 14) Community Mobilization
 - : methods to contact community groups - no clear guidelines
 - : ability to respond to community requests - unclear
 - : PHC enumeration varies
 - : role of VHWs and TBAs in urban EPI varies by LGA
 - : sustainability of VHWs (greater potential)
- 15) Causes of Incomplete Coverage
 - : drop-out high
 - : defaulter tracing methods unsuccessful
 - : all opportunities not used
 - : health education incomplete
 - : obstacles to attending health centres
 - : lack of acceptance by parents
 - : cost (time, money)
 - : lack of continuous feedback on performance

Interview with LGA management team

A. GENERAL INFORMATION

1. LGA: _____

DATE _____

2. Interviewer _____

3. Respondents : Name Position

| |
|--|
| |
| |
| |

4. GEOGRAPHICAL/ECOLOGICAL CHARACTERISTICS

4.1 Location

4.2 Special geographical characteristics

5. POPULATION SIZE AND DISTRIBUTION

5.1 Total area of LGA : _____ sq km/sq mile;

5.2 Total LGA population : _____ year: 19__ ;

6. COMMUNICATIONS

6.1 Are any health facilities inaccessible from the LGA centre for >=1 wk/yr?

No ___ Yes : note number of weeks inaccessible each month

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| J | F | M | A | M | J | J | A | S | O | N | D |
| | | | | | | | | | | | |

6.2 Do any of the following means of communication function between the state/ Ministry of Health and the LGA centre?

Communication To state To FMOH
from LGA

| | | | |
|---------------|--|--|--|
| Telephone | | | |
| Two-way radio | | | |
| Other (state) | | | |

6.3 Do any of the following means of communication function regularly between the centre and other health facilities within the LGA?

Communication Number of facilities served

| | | | |
|---------------|--|--|--|
| Telephone | | | |
| Two-way radio | | | |

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B. LGA HEALTH SERVICES AND SUPPORT SYSTEMS

1. MAP

Obtain a map showing: health facilities by type, schools, major population concentrations, communications (road/rail etc), churches, major markets or trading posts.

2. NUMBER AND TYPE OF HEALTH FACILITIES WITH COLD CHAIN:

| Type of facility | Govt | Mission | NGO |
|------------------|------|---------|-----|
| LGA hospital | | | |
| Other hospital | | | |
| Health centre | | | |
| Dispensary | | | |
| Health post | | | |
| Other (specify) | | | |

3. TRANSPORT

3.1 Record number of vehicles, place allocated and functional status:

| Type | Functioning | | | | Number available | | | |
|-------------|-------------|---------|---------|------|------------------|---------|---------|------|
| | LGA | Hosp(G) | Hosp(M) | PHCU | LGA | Hosp(G) | Hosp(M) | PHCU |
| Cars | | | | | | | | |
| Motorcycles | | | | | | | | |
| Bicycles | | | | | | | | |

3.2 Are any of the above vehicles attached to special programmes? No (go to 3.4)

Yes : number in each : EPI__ Other__

3.3 If YES, are they shared with other programmes? Commonly __
Occasionally __ No __

3.4 Is there a Health education public enlightenment van? Does it work?

3.4 Is public transport available between the LGA centre and:
all or most health facilities __ few or no health facilities __

3.5 Is public transport available between one health facility and another:
all or most health facilities __ few or no health facilities __

3.7 Do health workers usually use the public transport system for their supervision/outreach work:

From LGA centre : Yes__ No__ DK__
From health facilities: Yes__ No__ DK__

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4. HUMAN RESOURCES

4.1 Number and type of health staff employed in LGA: list available? Yes__ No__

| | LGA | Hosp(G) | Hosp(M) | PHCU | Community |
|------------------------|-----|---------|---------|------|-----------|
| Physicians | --- | --- | --- | --- | --- |
| Med assistants | --- | --- | --- | --- | --- |
| Trained nurses | --- | --- | --- | --- | --- |
| Trained midwives | --- | --- | --- | --- | --- |
| Student nurses | --- | --- | --- | --- | --- |
| Trained TBAs | --- | --- | --- | --- | --- |
| Comm hlth workers | --- | --- | --- | --- | --- |
| Ungraded support staff | --- | --- | --- | --- | --- |
| Other (specify) | --- | --- | --- | --- | --- |

4.2 Who is responsible for the following activities/programmes:
 Grade/category full-time part-time

| | | | |
|------------------------|-------|-------|-------|
| EPI | _____ | _____ | _____ |
| MCH | _____ | _____ | _____ |
| F.P. | _____ | _____ | _____ |
| TB | _____ | _____ | _____ |
| Malaria | _____ | _____ | _____ |
| H.Info | _____ | _____ | _____ |
| Community mobilization | _____ | _____ | _____ |

4.3 Are there TBAs in this LGA? Yes: Number ____ No ____

4.4 How many have been trained by the formal health services? ____

4.5 How many work with EPI?

4.6 What NGO facilities and programmes operate in this area?

| NGO (include church groups) | Main programme area | Activities in Hosp/HC/community |
|-----------------------------|---------------------|---------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

5. CONTINUING EDUCATION (CE)

5.1 Number and type of staff that received CE in last 5 years

| Staff type | Place of work (LGA/Hosp(G)/Hosp(M)/PHCU) | Place trained (national/state/LGA) | Subject of course (eg EPI/MCH,F.P.) |
|----------------------|--|------------------------------------|-------------------------------------|
| Doctor | | | |
| Nurse | | | |
| Medical asst | | | |
| Public hlth nurse | | | |
| Health administrator | | | |
| Other (specify) | | | |

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5.3 Who decides what courses/workshops are held in your LGA?

Local govt ___ LGA___ State ___ FMOH ___ Donors ___ Other___

5.5 Do you keep track of the courses attended by different health staff in your LGA?

Information readily available ___ Not readily available ___

5.6 Are there health training facilities in the LGA?

| Type of institution | No. serving | | |
|-----------------------------------|-------------|-------|--------|
| | LGA | State | Nation |
| Nurse training schools | _____ | _____ | _____ |
| Midwifery training schools | _____ | _____ | _____ |
| Community health training schools | _____ | _____ | _____ |
| Others (specify) | _____ | _____ | _____ |

5.7 Are these schools involved in providing in-service training to health workers?

No ___ Yes ___

6. SUPPORT SYSTEMS

6.1 How many supervisory visits have been made by the LGA to PHCUs during the last 3 months? ___

6.2 Which persons conducted supervision?

Medical officer _____
 Nursing officer _____
 Administrator _____
 Supervisor of specific programme _____
 Other (state) _____

6.5 How long do you spend per health facility during an average supervisory visit? ___ hrs ___ days

6.6 Do you use supervisory protocols/checklists? Yes ___ No ___

6.7 If yes, which programmes/activities are included? All ___
 EPI___ Others ___

6.8 What are the main constraints to supervision in this LGA? _____

6.10 Has any formal assessment been done of the quality of immunization practices in this LGA? Yes___ No___

If yes, is there a report we could see?

7. MAINTENANCE AND REPAIR

7.1 Is there a facility for repair of cold chain equipment when broken?

LGA ___ State ___ National ___ None ___

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7.2 Have you sent any equipment there for repair during the last six months?

Yes ___ No ___(go to 9.4)

7.3 If YES, has it been returned? Yes, still working ___ Returned but broken again___ No___

7.4 If NO, why not? Not needed ___ No transport available ___ No funds ___ Other (specify)_____

7.5 Is there a facility for repair and maintenance of vehicles ? No___ (go to 9.10) Yes:LGA ___ State ___ National ___

If YES:

7.6 Is it general or programme-specific? General ___ EPI___ Other ___

7.7 Have you sent any vehicle there for repair during the last six months?

Yes ___ No ___(go to 9.9)

7.8 If YES, has it been returned? Yes, still working ___ Returned but broken again___ No ___

7.9 If NO, why not? Not needed ___ No transport available ___ No funds ___ Other(specify)_____

7.10 Is there anyone on the LGA charged specifically with looking after maintenance of cold chain equipment___ ; vehicles ___?

8. VACCINE SUPPLIES AND VACCINATION STRATEGIES

8.1 Current stock of:

DPT vaccine _____
Measles vaccine _____
Tetanus toxoid vaccine _____
Polio vaccine _____
BCG vaccine _____

8.2 Has this LGA ever been out of vaccines in the last year? Yes___ for how long_____ No ___

8.3 How do you estimate your vaccine requirements?
- based on use during previous stock period ___
- based on estimated target population ___
- other (describe) _____

8.4 Does the LGA store supply vaccines to all health facilities or do some have other vaccine supply mechanisms? All ___ Some___ describe other supply source:

Prompt: Do all private facilities get vaccines from the LGA?

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8.5 What proportion of vaccinations are given at static sites in this LGA?

_____ %

8.6 How often do you do outreach vaccination?

Routinely _____/month

Blitz _____/month

8.7 How many outreach sites do you have?

Routine visits _____

Blitz _____

8.8 How do you select outreach sites to visit?

Community requests _____

PHC committee decides _____

Based on EPI manager's knowledge _____

State decides _____

Other (specify) _____

8.9 Do you monitor attendance by under-two year olds at outreach visits?

Yes ___ Explain how _____ No ___

8.10 On average, about how many children do your teams vaccinate in each outreach visit?

Routine _____/visit

Blitz _____/visit

8.11 Does the outreach team go from the LGA or from health centres?

LGA ___ Health centers ___

8.12 Do you have a mechanism for tracking defaulters in this LGA?

Yes ___ No ___

If yes, describe

9. HEALTH INFORMATION

9.1 Do you routinely receive information from peripheral health facilities on the following activities?

| Activity | Available | |
|--------------------|-----------|--------|
| | Yes ___ | No ___ |
| Outpatient visits | Yes ___ | No ___ |
| Inpatients | Yes ___ | No ___ |
| Under-five clinics | Yes ___ | No ___ |
| Immunizations | Yes ___ | No ___ |
| Outreach clinics | Yes ___ | No ___ |

9.2 Do you prepare summaries of this information on a regular basis?
No ___ Yes ___: Available ___ n.a. ___

9.3 Do you send these summaries anywhere? State ___ Ministry ___
Reporting health units ___ Nowhere ___

9.4 Do you use this information in your work? Yes ___ No ___

9.5 Do you have written guidelines on the following surveillance activities (observe manual if available):
case definitions for : NNT ___ Measles ___ Polio ___ Other ___
how to complete surveillance forms ___
how to analyse data ___
how to interpret trends ___

9.7 Ask for and record, where available, the following information:

Number of cases of disease and other conditions reported in 1991 and 1985 (if 1985 figures not available, put earliest year's data)

| <u>Disease/condition</u> | 1991 | 1985 |
|--------------------------|------|------|
| ARI | | |
| Measles | | |
| Malaria | | |
| Chickenpox | | |
| NNT | | |

9.8 If other sources of information exist on morbidity and mortality rates from these diseases (eg special surveys), note results.

| Disease | Source/date | Incidence rate | Mortality rate |
|---------|-------------|----------------|----------------|
| | | | |

9.10 Service provision

Estimated coverage trends of major services (state if data routine or survey) (if coverage not available, note number of activities reported)

| | 1991 | 1988 | 1985 | 1982 |
|-----------------------|-------|-------|-------|-------|
| EPI | | | | |
| OPV 3 | _____ | _____ | _____ | _____ |
| DPT 3 | _____ | _____ | _____ | _____ |
| Measles | _____ | _____ | _____ | _____ |
| BCG | _____ | _____ | _____ | _____ |
| TT | _____ | _____ | _____ | _____ |
| Hospital births | _____ | _____ | _____ | _____ |
| Antenatal care: | | | | |
| 1st visits | _____ | _____ | _____ | _____ |
| repeat visits | _____ | _____ | _____ | _____ |
| Consultations 0-4 yrs | | | | |
| 1st visits | _____ | _____ | _____ | _____ |
| repeat visits | _____ | _____ | _____ | _____ |

9.11 Is there any evidence that any analysis/use is being made of the records in the LGA?
 Graphs seen ___ Tables seen ___ Annual reports prominent ___
 Other (state) _____

10. PLANNING AND MONITORING SYSTEMS

- 10.1 Is there a national health plan that guides your work?
 Available ___ Not available ___ None exists ___
- 10.2 Is there a health plan for this LGA? Yes ___ No ___
- 10.3 If yes, does it cover all services or just specific programmes?
 All ___ Specific programmes ___ : EPI ___ Other ___
- 10.4 Who writes the plan? _____
- 10.5 Who approves the plan? _____
- 10.6 Who determines priorities among programmes? Local govt ___
 LGA ___ State ___ Federal MOH ___ Donors ___
- 10.7 Does the plan specify who does what and when? (review plan)
 No ___ Yes, comprehensively ___ yes, for certain programmes
 (specify which) : EPI ___ Other _____
- 10.8 Do you have numeric targets for the number of vaccinations to
 conduct this year? Yes ___ No ___
 If yes, what are they?
 Vaccine Number of doses to administer
- | | |
|-----------|-------|
| BCG | _____ |
| DPT/OPV 1 | _____ |
| DPT?OPV 2 | _____ |
| DPT/OPV 3 | _____ |
| Measles | _____ |
| TT 1 | _____ |
| TT 2 | _____ |
- 10.9 Who sets the targets?
- 10.10 Do you have any methods/approaches for identifying groups at
 great risk (Deprived communities)?
 a. in medical terms? Yes ___ No ___ DK ___
 b. in socio-economic terms? Yes ___ No ___ DK ___
- 10.11 If yes, which are the groups at highest risk in this LGA?
 a. in medical terms? _____
 b. in socio-economic terms? _____
- 10.12 Do you have any special programmes or services targetted to
 these groups?
 No ___ Yes ___ (describe)

11. BUDGETING AND RESOURCE ALLOCATION

11.1 Do you have this year's/last year's budget (estimates) for recurrent costs? Available ___ Not Available ___

11.2 Of the recurrent budget, how much is allocated to the following:

| Item | This year | Last year |
|-----------------------|-----------|-----------|
| Salaries | _____ | _____ |
| Drugs and supplies | _____ | _____ |
| Transport | _____ | _____ |
| Travel allowances | _____ | _____ |
| Maintenance | _____ | _____ |
| Other operating costs | _____ | _____ |

11.3 Were you involved in developing this budget? Yes ___ No ___: state who developed _____

11.4 Who approves this budget? _____

11.5 What proportion of the budget comes from:
Local govt _____
FMOH _____
SMOH _____
Local NGOs _____

11.6 Is there any flexibility for re-allocation of funds between items?
Yes ___ No ___ DK ___
If yes, who has the authority to make these changes?

12. FINANCING

12.1 Are consumers routinely charged for curative health services in your LGA? No ___ Yes ___
If YES, is it fee for service (state cost) ___
Drug purchases _____
Health insurance _____
Other (state) _____

12.2 Are consumers routinely charged for preventive health services in your LGA?
No ___ Yes ___
If YES, is it fee for service (state cost) ___
Inscription fee _____
Health insurance _____
Other (state) _____

12.4 Who decided on the financing mechanisms in your LGA?
LGA ___ LGA administration ___ SMOH ___
FMOH ___ Ministry of Finance ___ DK ___

12.5 Were community representatives involved in the decision? No ___ Yes ___ (state who and how)

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12.6 What is the policy for those unable to pay?

12.7 How is the income from fees used and by whom?

13. LGA DEVELOPMENT COMMITTEE

13.1 Is there a LGA development committee? No__ (go to 15.6) YES:
 list members:

| Members | Attendance regular | Role defined |
|---------------------------|-----------------------|--------------|
| Health: LGA director | _____ | _____ |
| hospital rep. | _____ | _____ |
| chief nurse | _____ | _____ |
| CHW rep | _____ | _____ |
| TBA rep | _____ | _____ |
| Private practitioners | _____ | _____ |
| Local govt | _____ | _____ |
| Other ministries | _____ | _____ |
| Missions | _____ | _____ |
| NGOs | _____ | _____ |
| Community representatives | _____ | _____ |
| Other (state) | _____ | _____ |

13.2 If yes, what are the functions of the committee?
 Written remit available__ Not available __

13.3 Do members have job descriptions / specific roles assigned to them?
 Written guidelines available __ Not Available__

13.4 How is this committee useful to you in planning and implementing EPI?

13.4 Is communication between government and NGOs in the LGA:
 Adequate__ Inadequate __

14. LGA PHC COMMITTEE

14.1 Is there a PHC committee? No__ (go to 15.6) YES: list members:

| Members | Attendance regular | Role defined |
|---------------------------|-----------------------|--------------|
| Health: LGA director | _____ | _____ |
| hospital rep. | _____ | _____ |
| chief nurse | _____ | _____ |
| EPI manager | _____ | _____ |
| Health educator | _____ | _____ |
| TBA rep | _____ | _____ |
| Private practitioners | _____ | _____ |
| Local govt | _____ | _____ |
| Other ministries | _____ | _____ |
| Missions | _____ | _____ |
| NGOs | _____ | _____ |
| Community representatives | _____ | _____ |
| Other (state) | _____ | _____ |

14.2 If yes, what are the functions of the committee? Written
remit available__ Not available __

14.3 Do members have job descriptions / specific roles assigned to them?
Written guidelines available __ Not Available__

14.4 If you want to conduct extra activities (outreach or mobilisation), how would you go about organising them?

15. COMMUNITY LEVEL ACTIVITIES/MOBILISATION

15.1. Are members from the community involved in any aspects of health-oriented community development, such as running of feeding centres, day care, treatment of diarrhoeal disease. Yes __
No __ (go to 15.8)

15.2. What functions do they participate in:

| | |
|--|-------|
| Health/nutrition education | _____ |
| Information of community about outreach visits | _____ |
| Door to door visits to check vaccination | _____ |
| Door to door visits for other interventions | _____ |
| Environmental sanitation | _____ |
| Running of day-care (feeding) centres | _____ |
| Management of specific disease problems | _____ |
| Volunteer health workers | _____ |
| TBAs | _____ |
| Other (specify) _____ | _____ |

15.3. When did the participation in health-related activities begin?

15.4. Have any community members received training in these activities from the health services? Yes __ No __

15.5. If yes, how many persons were trained: _____

When (years) 19__ - 19__
 Where: LGA hospital ___ Health centre ___ In community ___
 At NGO ___ Other (specify) _____

15.6. How did community participation in health activities begin?

Community requested local government ___
 Community requested health services ___
 NGO contacted community ___
 LGA health team contacted community ___
 Other (specify) _____

15.7 Which are the most active community groups in this LGA?

| | In 1990: | Now |
|---------------------------|----------|-----|
| JAMATU | ___ | ___ |
| Rotary | ___ | ___ |
| Soroptomists | ___ | ___ |
| Lions/Lionesses | ___ | ___ |
| Market womens association | ___ | ___ |
| Womens association | ___ | ___ |
| Inner wheel | ___ | ___ |
| Scouts | ___ | ___ |
| Guides | ___ | ___ |
| Red Cross | ___ | ___ |
| Other (state) _____ | ___ | ___ |

15.8 How often do community members meet with health service personnel (including visits by health staff to the community as well as formal meetings)?

At least monthly ___ Every 2-3 months ___ Two-three times per year ___ Irregularly ___

15.9 When was the last time the community and health staff met?

15.10 Has the community cooperated with, and completed any health-related community project in the past year? Yes ___ No ___ DK ___

if yes, specify which _____

VOLUNTEER HEALTH WORKERS

16.1 Are there lay health workers, such as Volunteer Health Workers (VHWs), specifically engaged in delivering primary health care services?

Yes ___ No ___ DK ___

If no, end of interview.

16.2 What specific functions do they perform?

Information-gathering ___
 Educating families (state subjects) _____
 Motivating families _____

Tracking defaulters from vaccination _____
 Providing simple treatment (eg ORS, chloroquine) _____
 Assisting outreach teams _____
 Other (specify) _____

16.4 Who selected/selects the volunteer health workers

LGA health team _____
 Programme coordinator at NGO _____
 Local administrator/chief _____
 Community leaders _____
 Other _____

(specify) _____

16.16 How are they paid?

none _____
 in-kind by community _____
 fee for service _____
 from local authorities _____
 from outside agency _____
 other _____

(specify) _____

16.6 Duration of initial training of VHW: _____ weeks _____ mths
 DK _____

16.7 Place of initial training of VHW : LGA hospital : _____

Health centre _____
 In community _____ At NGO _____
 Other (specify) _____

16.8 Do practising VHWS receive written instructions, eg a manual,
 treatment guidelines etc? No _____ Yes _____ (may I see it?)

16.12 Do trained health staff supervise VHWS? Yes _____ No _____
 DK _____

16.16 Does the VHW dispense medicine? Yes _____ No _____

16.16 How does the VHW replace his/her stock of medicines?

Visits health centre _____
 Visits LGA centre _____
 Written requisition _____
 Outreach team brings _____
 Other (specify) _____

16.18 How many VHWS have been trained from this LGA? _____

16.19 How many VHWS are currently working in this LGA? _____

17. Special vaccination activities in 1990 : DESCRIBE OVER PAGE

END OF INTERVIEW.

Invite representatives from the LGA to the working session and review meeting

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Interview with LGA management team

Questions they may need to look for reports to answer

Map

Obtain a map showing: health facilities by type, schools, major population concentrations, communications (road/rail etc), churches, major markets or trading posts.

2. NUMBER AND TYPE OF HEALTH FACILITIES WITH COLD CHAIN:

| Type of facility | Government | Private | NGO |
|------------------|------------|---------|-----|
| LGA hospital | | | |
| Other hospital | | | |
| Health centre | | | |
| Dispensary | | | |
| Health post | | | |
| Other (specify) | | | |

4. HUMAN RESOURCES

4.1 Number and type of health staff employed in LGA: list available?

| Yes__ No __ | LGA | Govt hosp | Mission hosp | PHC center |
|------------------------|-------|-----------|--------------|------------|
| Physicians | _____ | _____ | _____ | _____ |
| Med assistants | _____ | _____ | _____ | _____ |
| Trained nurses | _____ | _____ | _____ | _____ |
| Trained midwives | _____ | _____ | _____ | _____ |
| Student nurses | _____ | _____ | _____ | _____ |
| Trained TBAs | _____ | _____ | _____ | _____ |
| Comm hlth workers | _____ | _____ | _____ | _____ |
| Ungraded support staff | _____ | _____ | _____ | _____ |
| Other (specify) | _____ | _____ | _____ | _____ |

5. CONTINUING EDUCATION (CE)

5.1 Number and type of staff that received CE in last 5 years

| Staff type | Place of work (LGA/Hosp(G) / Hosp (M)/ PHCU | Place trained (national/ state/ LGA) | Subject of course (eg EPI/MCH,F.P). |
|----------------------|--|---|---|
| Doctor | | | |
| Nurse | | | |
| Medical asst | | | |
| Public hlth nurse | | | |
| Other (specify) | | | |

Hosp (G) =
govt hospital

Hosp (M) =
mission hospita

PHCU = primary
health cen

HEALTH INFORMATION

9.7 Ask for and record, where available, the following information:

Number of cases of disease and other conditions reported in 1991 and 1985 (if 1985 figures not available, put earliest year's data)

| <u>Disease/condition</u> | 1991 | 1985 |
|--------------------------|------|------|
| ARI | | |
| Measles | | |
| Malaria | | |
| Chickenpox | | |
| NNT | | |

9.8 If other sources of information exist on morbidity and mortality rates from these diseases (eg special surveys), note results.

| Disease | Source/date | Incidence rate | Mortality rate |
|---------|-------------|----------------|----------------|
| | | | |

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9.10 Service provision

Please note number of the following activities reported

| | 1991 | 1988 | 1985 | 1982 |
|-----------------------|-------|-------|-------|-------|
| EPI | | | | |
| OPV 3 | _____ | _____ | _____ | _____ |
| DPT 3 | _____ | _____ | _____ | _____ |
| Measles | _____ | _____ | _____ | _____ |
| BCG | _____ | _____ | _____ | _____ |
| TT | _____ | _____ | _____ | _____ |
| Hospital births | _____ | _____ | _____ | _____ |
| Antenatal care: | | | | |
| 1st visits | _____ | _____ | _____ | _____ |
| repeat visits | _____ | _____ | _____ | _____ |
| Consultations 0-4 yrs | | | | |
| 1st visits | _____ | _____ | _____ | _____ |
| repeat visits | _____ | _____ | _____ | _____ |

10.8 Do you have numeric targets for the number of vaccinations to conduct this year? Yes___ No___

If yes, what are they?

| Vaccine | Number of doses to administer |
|-----------|-------------------------------|
| BCG | _____ |
| DPT/OPV 1 | _____ |
| DPT/OPV 2 | _____ |
| DPT/OPV 3 | _____ |
| Measles | _____ |
| TT 1 | _____ |
| TT 2 | _____ |

8.1 Current stock of:

| | |
|------------------------|-------|
| DPT vaccine | _____ |
| Measles vaccine | _____ |
| Tetanus toxoid vaccine | _____ |
| Polio vaccine | _____ |
| BCG vaccine | _____ |

11. BUDGETING AND RESOURCE ALLOCATION

11.1 Do you have this year's/last year's budget (estimates) for recurrent costs? Available ___ Not Available ___

11.2 Of the recurrent budget, how much is allocated to the following:

| Item | This year | Last year |
|-----------------------|-----------|-----------|
| Salaries | _____ | _____ |
| Drugs and supplies | _____ | _____ |
| Transport | _____ | _____ |
| Travel allowances | _____ | _____ |
| Maintenance | _____ | _____ |
| Other operating costs | _____ | _____ |

Appendix 3

Persons Contacted

Federal Ministry of Health

Dr. A.O.O. Sorungbe, Director of Primary Health Care
Dr. M.D. Adedeji, Assistant Director, EPI/CDD/ARI (PHC)
Mr. G.A. Chiazor, Statistician, EPI/CDD Unit
Mrs. Felicia Asoegwu
Mrs. Marie Enumah
Mr. John Olasogba

Lagos State Ministry of Health

Dr. M. Ola Oduwole, Director, Primary Health Care
Dr. (Mrs.) M.E. Mosanya, EPI Manager
Mrs. B.O. Oyem, Assistant EPI Manager

Lagos State Local Government Areas (LGAs)

Dr. (Mrs.) O.O. Campbell, Medical Officer of Health, Ojo LGA
Mrs. P.A. Adenubi, Chief Nursing Officer, Ojo LGA
Mrs. G.O. Bajomo, EPI Manager, Ojo LGA
Mr. J.A. Ogunkoya, Supervisor, Health & Environmental Services, Ojo LGA
Dr. J.O. Adelouji, Medical Officer of Health, Ikeja LGA
Dr. Oshunniyi, Assistant Medical Officer of Health, Ikeja LGA
Mr. Okunuga, Notifiable Disease Statistician, Ikeja LGA
Mrs. L.O. Koleosho, EPI Manager, Ikeja LGA
Dr. Olufemi Onanuga, Deputy Medical Officer of Health, Lagos Island LGA
Dr. (Mrs.) Omotosho, Director of Medical Services, Lagos Island LGA
Mrs. S.A. Oki, Chief Nursing Officer, Lagos Island LGA
Mrs. A.A. Oke, EPI Manager, Lagos Island LGA
Dr. E.K.O. John, Medical Officer of Health, Lagos Mainland LGA
Dr. (Mrs.) Omoloja, Lagos Mainland LGA
Dr. (Mrs.) Fasesin, Lagos Mainland LGA
Mr. Adewole, Assistant Chief Medical Records, Lagos Mainland LGA
Dr. (Mrs.) Williams, Medical Officer of Health, Surelere LGA
Mrs. Jaiyesimi, EPI Manager, Surelere LGA
Mr. Bada, Storekeeper, Surelere LGA
Dr. M.Y.I. Salami, Medical Officer of Health, Mushin LGA

Hospital Management Board

Dr. O.R. Disu

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USAID/Nigeria

Mr. Eugene Chiavaroli, A.I.D. Administrative Affairs Officer
Mr. Modupe Broderick, TAACS Advisor
Ms. Helen Nwabuoku, Project Assistant
Mr. James Herrington, USAID/CCCD Consultant
Dr. Rick Spiegel, Epidemiologist
Mr. David Bassett, CDC, Atlanta

UNICEF/Nigeria

Dr. V.P. Kimati, Chief, Health Section

WHO/Nigeria

Dr. H.C.A.M. Van Vliet, Epidemiologist

Nigerian Medical Association

Dr. B. Oye-Ademiram, 1st Vice President
Dr. Sam Agbo
Dr. Mike A. Ileka, Director Gemics Clinics

Community Health Development Program - Mushin

Chief J.O. Obayomi, Project Director

Rotary/PolioPlus

Mr. N.M. Okwechime, National Chairman

Appendix 4

LGA EPI Managers Focus Group Meeting
Evaluation and Planning Session for Urban EPI in Nigeria and Meeting Agenda

Summary of successes identified by EPI managers:

- 1) Organization of out of hours clinics
 - : evening, in neighborhoods and/or markets
 - : weekends, in TBA clinics, neighborhoods and/or markets
 - : special days/weeks each month during Blitz activities
 - : going to each stall in markets to vaccinate children
- 2) Mobilization for immunization: high awareness about EPI (although it may be lower for TT than for childhood immunizations).
- 3) Involving NGOs
 - : in service provision at NGO-supported clinics
 - : in defaulter tracing
- 4) Incentives during UCI for complete vaccination (given by UNICEF and NGOs): T-shirts; exercise books
- 5) Use of a "fully immunized" certificate for educating mothers about the need to complete the schedule
- 6) Proposed school laws for childhood immunization and TT may help educate mothers about the need to complete immunizations. However, need to take care not to give the false impression that immunization can be delayed until school entry - need to emphasize immunization of young infants.

Note: Most LGAs mentioned extra activities that had been organized as their successes. Some LGA managers had used their own vehicles for transport. Not all activities were sustained after UCI because of lack of resources. Need to consider the cost-effectiveness of outreach activities and the potential to target these activities to the neighborhoods in greatest need.

Constraints/problems identified by EPI managers:

- 1) Lack of data for planning and evaluation
 - : census data
 - : reports from some private clinics
 - : supervisory reports from visits using checklists
 - : information on target disease morbidity and mortality
- 2) Turnover of personnel
 - : EPI managers (of 12 managers, 9 have been in post for less than 1 year).
 - : LGA councils
 - : clinic nurses
- 3) Lack of imprest or of delegation of authority to the EPI manager, so that funds are not readily available for small expenditures and can paralyse services.
- 4) Daily immunization not done at all static sites
 - : concern about vaccine wastage
 - : regular vaccine supply needed
 - : difficult to change old habits

- 5) Missed opportunities at curative services
 - : mothers do not take immunization cards
 - : health workers may be reluctant to vaccinate sick children
 - : vaccines may not be available at these services
- 6) Not all personnel are motivated. Sometimes see a big difference when the LGA EPI team goes to vaccinate at a health center or outreach site compared to local health center team which does less.
- 7) Certain groups do not accept vaccination
 - : market women at certain times
 - : religious groups
 - : migrants
- 8) Incomplete integration of private sector
 - : criteria for receiving vaccines
 - : vaccine shortages occur
- 9) Management of vehicles (EPI and health education)
 - : LGA councils need to be sensitized so as not to divert PHC vehicles to other services., eg health education.

Important activities to improve the existing EPI in Lagos City (identified by EPI managers):

- 1) Improve vaccine supplies to health centers;
- 2) Strengthen static services: provide daily immunization at all static sites;
- 3) Workshops for LGA chairmen to improve financial management and increase political support;
- 4) Workshops for private clinics;
- 5) Regular supervision using checklists, giving in-service training on problem areas, at all levels (including Federal support to State level);
- 6) Allow EPI managers to handle imprests;
- 7) Give incentives to parents for child to finish series (maybe school laws will accomplish this);
- 8) Maintenance and correct use of EPI vehicles and health education vehicles;
- 9) Organize clinics in a way which allows mothers who come only for immunization to get served quickly ("immunization express lanes"), to reduce waiting times;
- 10) Increase health education to remind mothers about appointments and to take immunization cards to curative clinics;
- 11) Clearer LGA objectives and plans for increasing coverage, based on better data;
- 12) Conduct defaulter tracing. Involve community groups and provide referral slips. Intensify the use of PHC committees.

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Agenda

Monday, 10 February 1992

13:30 - 16:30

- 13:30 Introduction
- 13:40 Review September Urban EPI Assessment (Questions and Answers) Ken Olivola
- 14:10 Review Findings from LGA/State Visits (Questions and Answers) Felicity Cutts
- Tea
- 14:40 Discussion with EPI Managers (Successes and Constraints) Felicia Asoegwu
- 15:30 List Urban EPI Objectives/Strategies/Activities

Participants:

LGA EPI Managers
SMOH EPI
FMOH EPI



Evaluation and Planning Session for Urban EPI in Nigeria

1.1 Strengthening static sites

The ideal: 2 vaccinators
2 NGOs (Boy Scout, Girl Guide, Rotary, Mamser)
1 mobilizer
1 recorder

Budget and imprest to supply all needs.

Activities : mobilization
daily immunization
screening
outreach stations
health education

An outreach station is a selected area where immunization is performed.

Organization of the area: mapping out the catchment areas to cover all areas with services

Microplanning: setting of targets

Solutions:

strengthen staff
imprest available
bar chart, illustrating the progress of activities to be conducted
supervision of all immunization centers and catchment areas
rapport between static sites and community to meet community needs.

1.2 Improving supervision/in-service training

Solutions:

Supervise manpower (skills adequate?); materials (cold chain, vaccines, thermometer, sterilization); organization of clinic including patient flow, health education especially about return appointments.

State should organize workshops:

Microplanning
Storekeepers/drivers
CDD
Steam sterilization
Private practitioners/nurses.

State should have adequately supplied Continuing Education centre.

Easy accessibility to facilitators.

Retain trained manpower (sensitive LG service commission).

2.1 High risk approach (identifying and targeting deprived neighborhoods)

Children < 1 year

Pregnant women and women of child-bearing age (15-45 years)

Migrants

Motherless babies in special homes, eg rehabilitation homes, destitutes, prison Barracks (soldiers, police)

Solution

- : home visits**
- : VHWs**
- : Immunization as part of matriculation.**
- : Visit rehabilitation homes to immunize.**
- : Intersectoral collaboration, eg work with Youth, Sport and Culture (now part of MOH).**
- : supply police and army nurses with vaccines, and conduct supervision to them.**

2.2 Cost-effective use of outreach

- : quarterly evaluation of activities to see if outreach is working**
- : Incentives to mobilizers, to make sure do work properly especially in evenings and weekends**
- : zoning of districts**
- : intensive mobilization using NGOs, VHWs, community development committee etc.**
- : maintain the vehicles**

3.1 Strengthening the cold chain and vaccine supply

Constraints:

- lack of trained personnel for cold stores**
- incessant change of personnel**
- ill-equipped cold stores**
- erratic power supply/no fuel for generators**
- 'underutilization of cold boxes at static sites**
- administrative protocol between the MOH and EPI managers in collecting vaccines**
- vehicles inadequate: maintenance and allocation**
- lack of adequate data on vaccines needs, use and rotation of stock**

Solutions :

- train at least 2 cold chain officers per LGA and ensure a permanent cold store officer**
- maintain equipment**
- ensure adequate statistics of equipment**
- use cold chain monitors**
- provide functional standby generator exclusively for EPI**
- improve estimation of vaccine requirement and provide what LGAs ask for**
- rotate stock (use old vaccine before new)**
- EPI managers should monitor vaccine usage**
- LGAs should help each other out**

3.2 Intensifying involvement of private sector

Constraints

- private hospitals operate on for-profit basis
- lack of adequate cold chain
- no direct link with LGAs
- returns/reports of vaccination not given to LGAs
- no adequate record keeping

Solutions

- LGAs should train at least 2 private hospital staff for cold chain and record keeping
- LGA should set up a body under the MOH to determine the total number of private institutions in the area and to relate directly with them.
- invite private hospitals to collect vaccines and give returns
- involve private sector in management committees
- the LGA should distribute educational materials to private facilities.

4.1 Strengthening EPI management

1. Vaccine management : regular supply of vaccine and maintenance of cold chain.
2. Political willingness: new policy makers (chairmen etc) need sensitizing.
3. Availability of funds: proper management of imprest accounts. Give EPI managers access. Separate budget from imprest funds. Guidelines on what should be included in the budget (annual budget plan, eg regular maintenance, fuel) and what should be in imprest (immediate needs).
4. Setting up LGA PHC committee. Some LGAs do not have this committee yet. EPI manager must be a member.
5. Training EPI managers: Since transfer cannot be stopped, each new EPI manager should receive training as soon as appointed.
6. Monitoring and supervision. Effective and regular supervision using checklists, from federal to state to LGA to health facility.

4.2 EPI health planning and data needs

Plan existing in LGAs are felt to be adequate. Need to obtain LGA census and use data for planning.

Annual LGA coverage surveys using WHO 30 cluster survey, with assistance from State (SMOH).

5.1 Improving defaulter tracing

1. Identify the causes of default
 - long waiting time
 - lack of knowledge of EPI diseases
 - lack of information on next appointment
 - economic issues (mothers need to work)
 - fear of vaccine reactions
 - time lag between the 3rd dose DPT and measles
 - superstitious beliefs

2. Solutions

- reduce waiting times by organizing the immunization session.
- mothers should be reminded about the next appointment eg at the exit table in the PHC clinic.
- education on reactions from vaccine and what to do.
- baby tracking of mothers by NGOs, health workers, one month or one week before immunization is due.
- identify day-care or pre-nursery schools and ask to monitor immunizations of the babies under their care.
- encourage the Functional Literacy Program to have EPI information included.

b. Ongoing regular community mobilization.

Solutions

- strengthen health education units
- weekend immunization
- market based services
- data collection on NGOs
- consultation meetings with NGOs
- time Blitz mobilization activities during school holidays. Train NGO trainers (TOT workshops).
- education in schools, including education about T.T.
- intensify health education in schools, clinics, market places, churches and mosques, NGOs and in villages.
- stress the importance of immunization, including T.T.
- use of mass media: radio, TV, newspaper.
- education of grandmothers, home helps on immunization.
- visit TBAs for T.T. (mobilization and vaccination).

Schedule

**Evaluation and Planning Session
for urban EPI in Nigeria**

Thursday, 13 February 1992

09:00 - 16:00

- | | | |
|-------|--|--|
| 09:00 | Introduction | Dr. (Mrs.) Adedeji; FMOH |
| 09:15 | Review September Urban EPI Assessment | Mr. Ken Olivola; REACH |
| 09:45 | Review "Successes and Constraints" to the EPI in 12 Lagos LGAs | Dr. Felicity Cutts; REACH |
| 10:15 | Tea | |
| 10:30 | List Priority Actions Identified with 12 LGA EPI Managers (Discussion) | Mrs. Felicia Asoegwu; FMOH Mr. Gideon Chiazor; FMOH |
| 12:00 | Presentation of Topics for Group Work (List Topics for Discussion) | Mrs. Felicia Asoegwu; FMOH Mr. Gideon Chiazor; FMOH |
| 13:30 | Lunch | |
| 14:30 | Group work (continuation) | |
| 15:30 | Group Presentations of Recommendations for Improving Urban EPI in 12 LGAs, Lagos State, and at Federal Level | |
| 16:00 | Close | Dr. (Mrs.) Adedeji; FMOH |

Participants:

LGA Medical Officers of Health
SMOH EPI
FMOH EPI
Others

UB

Appendix 5
FMOH and SMOH Workplans

