

REACH EPI STRATEGY FOR ECUADOR LONG-TERM INTERVENTION

January 1989

Resources for Child Health Project

REACH



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The Resources for Child Health Project
1100 Wilson Blvd., Ninth Floor
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Glossary

EPI	Expanded Program on Immunization
FC	Field Coordinator
MSP	Ministry of Public Health
PAHO	Pan-American Health Organization
PREMI	Plan for Reduction of Infant Morbidity and Mortality
REACH	Resources for Child Health Project
TBA	Traditional Birth Attendant
TDY	Temporary Duty
USAID	United States Agency for International Development
WHO	World Health Organization

I. Background

USAID has been intensively involved in child survival programs in Ecuador. Since 1985, they have supported the National Plan for Reduction of Infant Morbidity and Mortality (PREMI) which is implemented by the MSP, with strong financial and long-term technical support from AID bilateral and central funds. In addition to their long-term contribution to PREMI, USAID has also supported staff assigned to UNICEF and PAHO.

PREMI has led seven nationwide vaccination campaigns during the past three years. AID also supports the National Institute for the Child and the Family (INNFA) which manages PREMI's social mobilization and promotion effort to stimulate demand for immunization, oral rehydration therapy and nutrition services. Besides immunization, PREMI has also supported delivery of oral rehydration, growth monitoring, and acute respiratory infection control.

As the focus of the MSP's immunization program changes from a heavy reliance on mass vaccination campaigns and as PREMI is due to finish its work by the end of 1989, the MSP and USAID are working towards the long-term institutionalization of immunization services. USAID is a co-signator along with the MSP and other external agencies to the National EPI Five Year Plan, 1987-1991. It has agreed to support procurement of cold chain equipment, training, supervision, communications, epidemiological surveillance, research, and evaluation.

In keeping with its emphasis on health assistance aimed for the benefit of maternal and child health, USAID and the Government of Ecuador will collaborate on a new child survival project beginning in 1989 which has five objectives:

- to reduce neonatal mortality;
- to improve infant and young child nutrition;
- to reduce acute respiratory infections;
- to reduce mortality from diarrhoeal diseases;
- to prevent mortality from vaccine preventable diseases.

USAID/Quito has prepared an excellent Child Survival Strategy document analyzing the health problems and describing the strategy to address them. Weak and highly centralized MSP management, absence of local training and supervision, and inappropriate and underutilized information systems are the principal constraints of MSP programs. The USAID project will strengthen management, administrative and information system capacities in targetted provinces and increase the central MSP's capacity in training, supervision, and information management.

The Resources for Child Health Project (REACH) is an initiative of the Office of Health within AID's Bureau for Science and Technology. REACH is designed to help developing countries and USAID offices to increase the impact of their child survival programs by providing technical support for immunization programs and for improved health care financing.

REACH has supported USAID/Quito since 1986 with several short-term technical consultations. An historical synopsis of REACH involvement in Ecuador appears in Annex 1.

REACH is committed globally to strengthening local capacity to deliver sustainable high-quality immunization services. The Ministry of Health (MSP) in Ecuador and USAID/Quito requested REACH in 1987 to provide technical support to the national immunization program in 1987. Together with other external agencies (PAHO, UNICEF, Rotary) participating in Ecuador's Expanded Program on Immunization (EPI), the MSP and USAID determined that a field-oriented supervisor was required to focus on improved implementation of immunization service delivery at operational levels. A scope of work was developed with the close collaboration of all the donors (Annex 2).

The EPI Field Coordinator (FC) was jointly identified by MSP and USAID and hired by REACH in September 1988. He was briefed in Washington by AID (S&T/H and LAC), REACH and PAHO. He is an Ecuadorian physician with public health field experience who will spend up to 15 working days per month in an effort to improve EPI field implementation. His principle tasks will be to work with provincial and canton staff to improve EPI programming, management, supervision, logistics, monitoring, and evaluation. These are the very areas identified by USAID as constraints which the new child survival project endeavors to overcome. The FC will complement TA provided by PAHO, UNICEF, and USAID locally, and by a sub-regional PAHO EPI advisor.

The mechanism for hiring the EPI FC by using AID central funds through the REACH contract is a novel one. All costs for the first 12 months are being borne by REACH. The salary (and benefits) are set at a level that the MSP itself can afford in order to avoid a future situation where field supervision is felt to be too costly or unsustainable. The level of salary was consistent with the need to attract this type of field person.

The EPI FC is supervised by the national EPI Director. He is backstopped technically and administratively by REACH. The FC submits his monthly reports covering his activities and findings to the EPI Director and to REACH, who shares them with USAID. A USAID vehicle previously provided to PREMI is available for the FC's field travel.

The REACH contract (Annex 3) with the FC stipulates a possible one-year extension. USAID has expressed its interest in a 100% buy-in to cover the extension, subject to available funds through the new child survival project and to its satisfaction with the quality of REACH back-up services. USAID expects REACH to provide substantial institutional back-up support, including short-term training on special subjects and a series of short-term specialty consultancies on various priority topics. The budget appears in Annex 4 and includes REACH support in local currency for salary;

per diem; gas, vehicle maintenance and repair; and internal air transport. The budget also includes costs of a briefing with AID and REACH in Washington for one week each year and costs for up to ten days of international training each year. Two visits each year to Ecuador of up to two weeks' duration by REACH staff are also supported by the budget.

As his direct supervisor, the national EPI Chief has developed a Provincial Plan of Work for the Central Level Technical Team (Annex 5), including a chronogram of activities through February 1989. The FC is a member of this central team and will be directed by the EPI Chief.

The FC has also prepared a list (Annex 6) of topics on which to concentrate at provincial level--in this case in Esmeraldas Province, where the MSP plans to assign him.

To a large extent, the FC's specific activities will be determined locally in keeping with the shift towards regionalization. However, with the completion of a REACH TDY in January 1989 during which extensive field visits were made with the FC to gain a better understanding of the current situation, it is now possible to provide more focused technical direction to the REACH FC. The following section, taken from the executive summary of the January 1989 TDY, outlines the key points which the FC will try to implement. These points have been discussed with USAID, PREMI, and MSP staff and are in close agreement with the thrust of USAID's new child survival project.

II. Situation Analysis

The Ministry of Public Health (MSP) and external agencies participating in Ecuador's Expanded Program on Immunization determined in 1987 that a field-oriented supervisor was required to focus on improved implementation of immunization service delivery at operational levels. The Ministry and USAID/Quito requested REACH to hire Dr. Jose Litardo as the EPI Field Coordinator and to provide him with the required technical support, including two short-term visits per year from REACH headquarters. This first visit, undertaken between 11-22 January 1989, included detailed discussions with USAID, MSP, PAHO, and UNICEF staff and a three-day field trip within Cotopaxi Province. The purpose of the field visit was to work alongside the Field Coordinator to demonstrate EPI supervisory techniques, identify strengths and weaknesses in the EPI, and formulate recommendations.

Centralized planning cannot cope with all the minute details (manpower availability and distribution, cold chain equipment and management, topographic and climatic factors, population distribution and settlement patterns, etc.) which must be factored into effective immunization service delivery. As part of its broader regionalization of health services, the MSP will require technical, managerial, administrative and logistic support for its EPI at provincial and canton "health area" levels. The need for persons who can provide this support, like the REACH EPI Field Coordinator, is absolutely essential to make regionalization work.

The EPI will rely on complementary strategies to deliver services, including province-wide immunization campaigns, outreach from health facilities to areas of concentrated population, house to house vaccination, and routine vaccination in response to "spontaneous demand" in health facilities. Overly passive and inefficient response in health units to current routine demand has limited the effectiveness of the latter strategy. Vaccination coverage among children less than one year of age for the year 1987, for the country as a whole and by province, appears in Annex 7.

Studies have found that 5% of all deaths nationally in children born during the past five years are due to neonatal tetanus, which remains in many areas possibly the most significant cause of easily preventable neonatal mortality. However, prevention of neonatal tetanus has been neglected relative to other EPI target diseases.

Many of the norms in use in Ecuador do not reflect internationally accepted WHO EPI policies and are explained further in the recommendations section.

A very useful graph for the monthly monitoring of immunization coverage is being introduced at provincial and canton levels. In many areas, a major problem for EPI is that 3rd doses are not completed before 12 months of age.

Supervision, which has consistently been identified in program evaluations as the weak link in the EPI in Ecuador, has become essential in the current regional attempt to program routine services at local levels. An EPI Supervisory Checklist, designed by the writer for operational levels in Bolivia, worked well on the field trip to focus on key information and raise important topics for on-the-spot training.

The cold chain is well-organized, although training in its management and supervision are needed. The cold chain will become relatively more difficult to manage once EPI shifts from campaigns to routine services, and local health facilities have a continuous stock of vaccine to store, rotate and use over time.

As vaccination coverage is lowest in Esmeraldas (DPT3 = 31%) and neonatal mortality rates are highest in rural coastal areas, REACH supports the MSP's decision to assign Dr. Litardo to Esmeraldas in 1989. Given the large unvaccinated population in nearby coastal provinces, REACH expects that Dr. Litardo can also assist there.

III. Areas of Future Involvement for Field Coordinator

Regionalization

1. As part of the planned regional restructuring of health services, the MSP needs to clearly define the roles and responsibilities for EPI of provincial and canton staff to ensure that "health

areas" are completely managed and supported. The canton hospital director could be made responsible for EPI within the health area.

2. The Inter-Agency Coordination Committee should meet as soon as possible and commit funds in support of activities planned for 1989, paying particular attention to the current shortage of vaccines in Ecuador.

Delivery strategies

1. Place more emphasis on routine outreach strategies from fixed posts, including schools and churches, in nearby populated areas so that periodic province-wide campaigns can concentrate on the more distant populations lacking access. This can be combined with house to house "channeling" of eligible children and women to the outreach post.
2. Design simple lesson plans for systematic use in schools, suggesting specific community activities, to harness the energy (and natural competition) of school children in promoting vaccination coverage.
3. Systematically screen, refer and vaccinate children daily in fixed facilities without fear of vaccine wastage and without excessive invalid contraindications, so that no opportunities to vaccinate are missed.
4. Work through community leaders and promoters to stimulate demand rather than passively responding to "spontaneous demand."
5. Intensify neonatal tetanus control efforts in areas of known or suspected higher incidence. Expand eligibility to all women of childbearing age. Screen and vaccinate them, as well as pregnant women, at every contact. Implement the WHO-recommended 5 dose schedule and record TT 1, 2, 3, 4, and 5 on long-lasting Tetanus Protection Cards and on statistical sheets. Immunize female students annually in each of the early grades. Require proof of a recent dose of TT for issuance of a marriage certificate. Use TBA's to promote TT vaccination. Include TT during campaigns.

EPI Norms

1. Revise and widely circulate EPI norms with the following changes which are internationally accepted:
 - inter-dose interval with polio, DPT and TT primary series can be shortened to 4 weeks.
 - TT should be given at first contact in any month of pregnancy.
 - infants receive 0.05 ml of BCG, 0.1 ml if more than 12 months of age.
 - some polio products require 3 drops.

- I.M. injections to young children should be given in the antero-lateral aspect of the thigh, never in the buttocks.
 - eliminate contraindications for BCG (<2500 grams), polio (vomiting and diarrhea) and TT (restricting TT to only 5th and 7th months of pregnancy).
 - include Polio Zero Dose at birth; polio administered to children with vomiting or diarrhea should not be counted as part of the series.
2. Any norms should include information on:
- importance of starting and finishing the series early.
 - safety and efficacy of immunizing children with all vaccines on same day.
 - not restarting interrupted schedules.
 - opening a vial even for one child.
 - giving measles vaccination unless documented history of measles or dated measles vaccination exists.
 - MSP policy concerning reuse of opened vials.

Monitoring Immunization Coverage

1. Rapidly implement in each province and canton the present plan to use a graph to monitor monthly the vaccination coverage, using 100% of eligibles as the target.
2. Broaden the criteria for identification of "critical areas" from present system based solely on vaccination coverage of less than 50%. Consider also the total population and the numbers of unvaccinated per canton.
3. Request funds from appropriate sources to translate into Spanish the revised "Coverage Survey" module from the WHO EPI Mid-level Manager's Course.

Supervision

1. Determine who will be responsible for technical supervision at each level, and with what frequency supervisory visits will be made.
2. Finalize design of a EPI Supervisory Checklist using Annex 8 as a model, field test it, and train supervisors in its use.
3. Require advance preparation at each level of a program of field supervisory visits which should be filed at the next higher level. Completed checklists should be submitted to the higher level and comments fed back to lower levels. Record immediate actions to be taken in a unit-maintained supervisory log book.
4. Prepare a menu of discussion topics and suitable materials to be used for provincial in-service training, where feasible, during monthly visits by rural health staff to collect salary.

Cold Chain

1. Consult Annex 9 to select suitable refrigerators.
2. Establish a stock of essential refrigerator spare parts and a system of replenishment in each province.
3. Do not despatch unsolicited vaccines from one level to the next.
4. Order some steam sterilizers and reusable syringes/needles (Annex 10) for testing at provincial or canton hospitals which have a centralized injection room to help solve the problem of inappropriate reuse of disposable syringes.
5. Do not rely on locally produced liquid BCG vaccine when ordering and despatching vaccines, as it cannot reach peripheral levels of the cold chain within its 15 day usable life.
6. Require provincial cold chain staff to do an actual monthly inventory of vaccine stocks and to adjust "cardex" files accordingly.

Research

1. Analyze by geographic area and by age at death in days currently available neonatal mortality data sets, since excess deaths above the declining mortality curve between 4 and 14 days are likely attributable to tetanus.
2. Conduct studies to determine the extent of the problem of missed opportunities for immunization. Include the review of vaccination cards for missed opportunities as a routine part of field supervision.

A useful model which will guide the Field Coordinator has been prepared locally by PREMI staff (Annex 11).

Annex 1

Synopsis of REACH Involvement in Ecuador

April 1986. REACH designed questionnaires for evaluation of PREMI national vaccination campaigns, including sections on cold chain, KAP of health workers and KAP of the population. Methods of analysis of sentinel surveillance data were suggested.

April-September 1986. A REACH team analyzed the immunization services based in fixed facilities versus those through a mass campaign during 1986. Cost results showed that the mass campaign was significantly more expensive than providing immunization service in fixed facilities. Despite this factor, the mass campaign did make significant contributions to immunization coverage for children under two years of age.

August-September 1986. An analysis of the contribution of national campaigns (conducted between October 1985 and June 1986) to vaccination coverage of children 0-4 years old was conducted. The analysis documents substantial achievement in the use of immunization and other child survival interventions during the campaigns.

February 1987. Consultants participated together with the Government of Ecuador, PAHO, UNICEF, USAID, and Rotary International in the technical and financial review of the proposed five-year multi-party EPI Plan of Action. A revised Plan was prepared and areas of potential USAID assistance were identified. REACH long and short-term technical assistance was proposed by the consultants.

September-October 1987. REACH developed a proposal for the placement of an Ecuadorian national as the REACH long-term EPI Field Coordinator which details a revised scope of work, job qualifications, a budget and a method of selecting the candidate.

October-November 1987. A REACH consultant was sent to design improved methods of collection and use of routine EPI data, identify future statistical needs, and analyze campaign and routine vaccination data. In addition, the consultant assisted the MOH in designing and conducting a mini-coverage/KAP surveys in rural and urban areas of Guayaquil.

September 1988. REACH staff visited Quito to hire a long-term EPI Field Coordinator selected by MOH and USAID officials. The coordinator began work in late September 1988 with a briefing by AID, REACH and PAHO in Washington, DC.

November 1988. REACH provided a consultant to complete an economic analysis for a Child Survival Project Paper (PP) in Ecuador. Since he discovered that much of the information required for the analysis was not yet available, he will return in January to complete the analysis and to conduct a more detailed economic study of the Ministry of Health in Ecuador.

January 1989. REACH staff accompanied the EPI Field Coordinator on a field trip to share supervisory techniques and provide technical support. They identified strengths and weaknesses in the EPI, and formulated recommendations. The long-term strategy for the REACH EPI Field Coordinator was discussed.

SCOPE OF WORK FOR THE REACH EPI FIELD COORDINATOR

Based on activities in the Five Year EPI Plan, the Field Coordinator will help the EPI to execute the following:

- Participate in planning and implementing a supervisory system for each level of EPI which includes supervisory checklists, analysis and consolidation of identified problems, and feedback of results and proposed solutions.
- Supervise field activities approximately 15 working days per month on visits to health units in selected provinces.
- Collaborate in planning strategies for accelerated implementation in collaboration with provincial authorities, such that all health facilities permanently offer vaccinations and conduct outreach activities in underserved areas.
- Monitor the integrity of the cold chain down to local levels by assuring proper maintenance of equipment and storage of vaccines.
- Implement the current re-supply system to ensure adequate quantities of vaccine and materials at provincial and local levels.
- Ensure a supply system of cold chain spare parts in coordination with those responsible for maintenance at provincial level.
- Participate in planning and execution of training courses organized by provincial technical teams.
- Strengthen routine epidemiological surveillance at provincial, canton, and local levels and improve timely case detection and notification, outbreak investigation and control measures.
- Strengthen the consolidation and local use (including graphic presentations) of routinely-collected information for program monitoring at provincial levels.
- Ensure field compliance with EPI norms and procedures.
- Identify the need for and participate in field studies and periodic evaluations.
- Provide input based on field experience in the design of basic guidelines for national re-programming.
- Ensure the flow and utilization of funds to provincial and local levels.
- Report regularly to the corresponding levels of MSP.
- The field coordinator will belong to the EPI team and therefore will be under the supervision of the EPI Chief. The coordinator will travel as necessary, after presenting his schedule of planned field activities to the EPI Chief for approval. The field coordinator will collaborate during his supervisory visits with other MCH problems.
- Engage in other duties as considered necessary by the Child Department.

REACH CONTRACT WITH EPI FIELD COORDINATOR

September 1, 1988

Dr. Jose Vicente Litardo Barzola
Quito, Ecuador

Dear Dr. Litardo:

This letter confirms your employment with the Resources for Child Health (REACH) Project effective 25 September 1988, for a period of 12 months terminating 24 September, 1989 with possible extension to August 31, 1990 subject to the availability of funds. You will serve as EPI Field Coordinator at an annual salary of S/.83,220 (eighty three thousand two hundred and twenty 00/100 sucres) payable monthly in local currency. The first four months of the assignment will be on a probationary basis, at the end of which your performance will be reviewed and evaluated by the REACH activity manager.

The job description of the EPI Field Coordinator is attached.

This employment contract is subject to the United States Agency for International Development rules and regulations and are subject to modifications by AID.

REACH will provide you with a small bank account in local currency to cover your internal travel and transport costs for gas, vehicle maintenance and repair, internal air transport, and per diem at the MSP rate scale, based upon your salary level and geographic area in which you spend the night. The account will also cover such direct costs as telephone, telex, postage and courier services in connection with your work. The account will be replenished monthly upon reconciliation of incurred expenses.

An insured vehicle will be assigned to you by PREMI and you will be expected to do your own driving. Approximately 15 working days per month, or more if necessary, are to be spent in the field.

You will be under the supervision of the EPI Chief who will arrange for your office space, desk and MSP stationery. Your REACH technical supervisor and activity manager will be Mr. Robert Steinglass. We would like you to report monthly to Mr. Steinglass with a summary of your activities and findings, and keep in touch at least monthly by telephone.

This contract provides you with the same holidays, number of vacation days, and number of sick days as provided by the MSP to its mid-level staff. You will need to follow MSP rules in the accumulation and exercise of this leave, including clearing vacation days in advance with the EPI Chief. Your working hours are from 8:00 A.M. to 4:30 P.M. Monday through Friday. REACH requires you to submit a monthly time sheet.

We intend to pay you a salary which includes benefits and a rate of per diem consistent with those offered by the MSP to a Medical 5 officer, with adjustments to keep pace with changes in salary and benefits mandated by the MSP.

REACH will pay you at the beginning of your contract for medical and life insurance policies, which you will be responsible to obtain and send to REACH. No other fringe benefits will be payable either by REACH or by USAID/Quito.

Your salary has been adjusted in such a way that you are also responsible for paying your own taxes, reserve fund, and IFSS contributions. We require you to submit evidence of these payments.

We anticipate your traveling to REACH in Washington very early in your assignment for a general orientation to REACH, including administrative procedures and a technical briefing.

I am very pleased to offer you this position and look forward to working with you. You have an important contribution to make to the national immunization program.

Please sign below to acknowledge your acceptance of the above salary and conditions.

Sincerely

(P.S.)
Norbert Hirschhorn

Norbert Hirschhorn, M.D.
Project Director, REACH

In case of discrepancies, the English version applies

I have read the above text and agree with the terms of this position.



Dr. Jose Vicente Litardo Barzola

11 Septembre / 85
Date

Attachment: Job Description
cc: Joel Lamstein, President, JSI,
Diane Hedgecock, Dep. Dir. REACH,
Pierre Claquin, Ass. Dir. REACH,
Mickey Vanden Bossche, Acc. REACH

CORRECTION OF REACH CONTRACT WITH EPI FIELD COORDINATOR

Resources for Child Health



REACH

Erratum

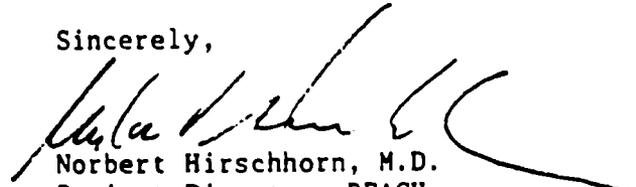
7 September, 1988

This erratum is in respect of the contract signed 1 September 1988 in Quito, Ecuador between Dr. Jose Vicente Litardo Barzola and Norbert Hirschhorn.

- Dr. Litardo will serve as EPI Field Coordinator at an annual salary of S/.998,640 (nine hundred ninety-eight thousand six hundred and forty sucres) payable monthly in local currency.

Please sign below to acknowledge your acceptance of the above salary and conditions.

Sincerely,



Norbert Hirschhorn, M.D.
Project Director, REACH

I have read the above text and agree with the terms of this position.



Dr. Jose Vicente Litardo Barzola

88-09-15

Date

- cc: Joel Lamstein, President, JSI
Diane Hedgecock, Deputy Director, JSI
Pierre Claquin, Associate Director, REACH
Mickey Vanden Bossche, Accountant, REACH

DETAILED FINAL REACH BUDGET FOR EPI FIELD COORDINATOR

All Figures Shown in US \$

	<u>FY88</u>	<u>FY89</u>	<u>TOTAL</u>
1. SALARY*	1920	2016	3935
2. INTERNAL TRAVEL AND TRANSPORT*			
a. gas, vehicle maintenance and repair**	1532	1608	3140
b. internal air transport	808	848	1656
c. per diem*** (6000 sucres x 20 days/month)	2769	2908	5677
3. FC TRAVEL TO REACH OFFICE (one week/year)			
a. air transport	1200	1260	2460
b. per diem (\$117 x 6 days)	702	737	1439
c. misc.	100	105	205
4. FC TRAVEL TO INTERNATIONAL TRAINING			
a. air transport	1000	1050	2050
b. per diem (\$100 x 10 days)	1000	1050	2050
c. misc.	100	105	205
5. REACH ST TECHNICAL ASSISTANCE (2 visits/yr, 2 weeks each)			
a. air transport (\$1200 x 2 trips)	2400	2520	4920
b. per diem (72 x 15 days x 2 trips)	2160	2268	4428
c. fee days (\$351 x 14 days x 2 trips)	9828	10319	20147
d. misc.	500	525	1025
6. REACH TECHNICAL AND ADMINISTRATIVE BACKSTOP	4000	4250	8250
7. OTHER DIRECT COSTS	3000	3100	6100
8. SUBTOTAL	33,019	34,669	67,688
9. FEE (5.07%)	1674	1758	3432
10. TOTAL	34,693	36,427	71,120

* payable in local currency

** insured PREMI vehicle assigned for field work

*** per diem paid at Ministry scale

Annex 5

Plan de Trabajo en las Provincias del Equipo Tecnico del PAI Nivel Central

1. Introduccion

El equipo del PAI, luego del análisis de la situación actual del programa a nivel nacional y por provincias, detecto los problemas presentados en el año de 1988 siendo estos de orden administrativo, en lo que se refiere a la adquisición de insumos y materiales (biológicos y jeringuillas) que no se suministro a las provincias, situación que incidió en las bajas coberturas que se mantienen aún por falta de biológicos sin que puedan a nivel operativo cumplir las actividades permanentes, sumándose la falta de supervisión del nivel central al provincial y de este al local, todo ello ha constituido factores principales para su ejecución.

Por consiguiente el programa cree conveniente tomar nuevas estrategias de trabajo para apoyar al personal técnico provincial asignando a los funcionarios del PAI la responsabilidad de cuatro provincias para su ejecución.

Además, dentro del Plan Quinquenal la contribución de las Agencias Internacionales del Programa permiten desplegar las actividades que a continuación presentamos.

2. Problemas

- bajas coberturas
- cumplimiento parcial normas
- falta de programación, monitoreo, análisis del PAI
- falta de educación continua según necesidades
- supervisión inadecuada
- poca participación comunitaria.

3. Objetivos

- a. Motivar y concientizar a autoridades y personal involucrado tanto a nivel provincial, cantonal y local sobre la correcta administración del programa.
- b. Lograr que las provincias dispongan una programación local del programa de acuerdo a recursos existentes.
- c. Desarrollar actitudes en el personal que conduce el programa para ejecutar actividades de capacitación y supervisión adecuadas.

- d. Identificar los recursos comunitarios que pueden y deben apoyar las actividades de vacunación.
- e. Reforzar en los diferentes niveles de atención el desarrollo permanente y efectivo del programa.

4. Estrategias y Actividades

- a. Reuniones de trabajo en los diferentes niveles con el fin de:
 - 1. Análisis, cualitativo y cuantitativo en el desarrollo del programa en 1988.
 - 2. Programación local de actividades.
 - 3. Determinación de responsabilidades según áreas y niveles.
 - 4. Información e instrucción sobre la administración del PAI.
- b. Seguimiento de las actividades programadas.
- c. Supervisión periódica y educación continua al personal operativo de la provincia.
- d. Monitoreo y evaluación de las actividades.

Cronograma de Actividades

FECHA	PROVINCIAS	RESPONSABLES	ACTIVIDADES	MATERIAL A UTILISAR
23-27-I-89	Carchi-Imbabura Cañar-Chimborazo Napo-Pastaza Manabi-Los Rios	Dra. Irlanda Ordoñez Dr. Jacobo Moreta Lcda. Lourdes Pazmiño Sub-region II	Evaluación Provincial Cantonal y Parroquial Programacion Actividades PAI	Formulario Coberturas de Vacunas Formulario de Programación
30-I-3-II-89	Cotopaxi-Tungurahua Morona Santiago Cañar-Azuay El Oro-Loja-Zamora	Dra. Irlanda Ordoñez Lcda. Lourdes Pazmiño Dr. Jacobo Moreta Sub-Region II	 Programacion Financiera	 No. eventos de CAP. No. visitas de SUP.
23-I-3-II-89	Esmeraldas	Dr. José Litardo		No. visitas técnico mantenimiento
13-17-II-89	Guayas Pichincha	Dra. Irland Ordoñez Dr. Jacobo Moreta	Inventario Recursos Cadena de frio	For. Recursos Cadena de frio

Annex 6

Situación Actual PAI Provincia Esmeraldas

- Número de unidades y su ubicación
 - o Cuáles vacunan
 - o Cuáles no vacunan
 - o Horario de atención
- Recursos humanos
- Recursos cadena de frío (refrigeradoras, termos, cajas frías, etc.) y su manejo (bueno, regular, malo, ninguno)
- Insumos de vacunación (jeringuillas, alcohol, etc.)
 - o Sistema distribución
- Biológicos existentes
 - o Conservación
 - o Ubicación
 - o Sistema distribución
- Población total y población objeto
 - o CENSO
- Sistema de información (PAI y Vigilancia) Monitoreo local
 - o Formularios
- Programación provincial y local (actividades, estrategias)
- Areas de riesgo
 - o Coberturas de vacunación por grupos de edad provincial, cantonal, parroquial
 - o Vigilancia epidemiológica
- Otros



COBERTURAS DE VACUNACION POR PROVINCIA

GRUPO DE EDAD: Menores de 1 año

Annex 7

AÑO: 1987

ECUADOR



PROVINCIA		POBLACION A VACUNAR	B.C.G.	D. P. T.			ANTIPOLIOMIELITICA			ANTISA RAMPI NOSA
				PRIMERA DOSIS	SEGUNDA DOSIS	TERCERA DOSIS	PRIMERA DOSIS	SEGUNDA DOSIS	TERCERA DOSIS	
CARCHI	No.	4131	4152	4183	4127	3521	4183	4120	3521	2749
	%	100	101	101	100	85	101	100	85	67
IMBABURA	No.	8782	8512	8272	7142	5362	8295	7159	5372	5070
	%	100	97	94	81	61	94	82	61	58
PICHINCHA	No.	50928	44304	37921	35139	29711	37838	35183	29465	23441
	%	100	87	74	69	58	74	69	58	46
COTOPAXI	No.	10517	10037	8883	6746	4360	8868	6727	4350	4484
	%	100	95	84	64	41	84	64	41	43
TUNGURAHUA	No.	10447	10120	9700	8683	7670	9700	8682	7670	6718
	%	100	97	93	83	73	93	83	73	64
BOLIVAR	No.	4900	4998	4690	3544	2688	4672	3602	2615	2764
	%	100	102	96	72	55	95	74	53	56
CHIMBORAZO	No.	13126	11793	10081	8000	5594	10063	7992	5604	5460
	%	100	90	77	61	43	77	61	43	42
CAÑAR	No.	6958	5392	4916	4092	2855	4914	4072	2852	2341
	%	100	78	71	59	41	71	59	41	34
AZUAY	No.	16721	13683	11767	9758	6850	11788	9765	6852	5626
	%	100	82	70	58	41	71	58	41	34
LOJA	No.	12964	9878	8999	6935	4644	8999	6935	4644	4584
	%	100	76	69	54	36	69	54	36	35
ESMERALDAS	No.	11456	7628	7979	6142	3505	7977	6107	3508	4264
	%	100	67	70	54	31	70	53	31	37
MANABI	No.	34533	29130	29332	24848	20550	29259	24968	20250	17923
	%	100	84	85	72	60	85	72	59	52
LOS RIOS	No.	16886	14047	14370	11679	8494	14622	11919	8718	8045
	%	100	83	85	69	50	87	71	52	48
GUAYAS	No.	74364	65787	65145	52800	38302	67829	52405	39636	37534
	%	100	88	88	71	52	91	70	53	50
EL ORO	No.	11810	10804	9828	8821	6836	9877	8685	6843	6192
	%	100	91	83	75	58	84	74	58	52
NAPO	No.	6548	2661	2357	1781	1052	2349	1783	1052	758
	%	100	41	36	27	16	36	27	16	21
PASTAZA	No.	1456	1044	1094	892	571	1094	892	571	614
	%	100	72	75	61	39	75	61	39	42
MORONA	No.	3678	2667	2611	2078	1041	2593	2076	1030	1388
	%	100	73	71	57	28	71	57	28	38
ZAMORA	No.	2413	2095	1979	1373	627	1974	1366	615	826
	%	100	87	82	57	26	82	57	25	34
GALAPAGOS	No.	264	142	165	182	123	177	181	124	110
	%	100	54	63	69	47	67	69	47	42
TOTAL PAIS *	No.	305404	258869	244272	204762	154356	247071	204619	155292	141491
	%	100	85	80	67	51	81	67	51	46

* Incluye zonas no delimitadas.

Annex 8

EPI Supervisory Checklist for Operational Levels

Health Facility: location _____
type _____

A. Interviews (Circle "Yes" or "No" where applicable.)

1. Name and Title of person(s) interviewed.

2. Knows total population in service area? Yes No

3. What is your annual target number of infants for vaccination? _____

4. How do you plan to increase vaccination coverage in the future?

- a. _____
- b. _____
- c. _____

5. What resources do you need to increase coverage?

- a. _____
- b. _____
- c. _____

6. Can you administer vaccinations more frequently than now? Yes No

7. Do you use RPS's or Promoters for:

- a. planning with community dates/times of vaccination sessions? Yes No
- b. informing community about dates/times? Yes No
- c. pre-registering eligibles for vaccination? Yes No
- d. screening and registering eligibles at vaccination site? Yes No
- e. vaccination? Yes No
- f. follow-up of defaulters for vaccination? Yes No
- g. discussing EPI with the community? Yes No
- h. feedback of vaccination results to community? Yes No

8. What are the problems in organizing RPS's and Promoters?

- | | | |
|---|-----|----|
| 9. Knows correct Ministry policies on: | | |
| a. age for vaccination by dose? | Yes | No |
| b. vaccination of ill children? | Yes | No |
| c. T.T. for women 15-44 and in any month of pregnancy? | Yes | No |
| 10. What do you do with used disposable syringes/needles? | | |

B. Review of Records

- | | | |
|--|------------|----------|
| 1. Frequency of vaccination sessions? | | |
| 2. Vaccination administered on outreach? | Yes | No |
| 3. Duplicate vaccination cards or register kept? | Yes | No |
| 4. Sufficient stock of: syringes/needles/cotton
vaccination cards/forms? | Yes
Yes | No
No |
| 5. Date of last supervisory visit to this facility?
By whom? (name and title) | | _____ |
| 6. Date of last supervisory visit to lower level?
By whom? (name and title and where) | | _____ |
| 7. Are vaccination statistics? | | |
| a. calculated and reported by dose and age? | Yes | No |
| b. accumulated for year in progress? | Yes | No |
| c. compared to annual targets? | Yes | No |
| d. used to estimate infant coverage? | Yes | No |
| e. displayed on wall | Yes | No |
| 8. Based on last 10 child vaccination cards: | | |
| a. Were more than 8 children given all
vaccinations appropriate to their age? | Yes | No |
| b. were more than 1/2 of last vaccinees children
less than 12 months old? | Yes | No |

C. Observations

- | | | |
|---|-----|----|
| 1. Do staff screen for vaccination status of each child and woman, and either vaccinate or appropriately refer? | Yes | No |
| 2. Is vaccination education given to each person on: | | |
| a. importance of vaccination? | Yes | No |
| b. some vaccine-preventable diseases using local names? | Yes | No |
| c. need for 3-4 visits before 12 months age? | Yes | No |
| d. where and when to get next doses? | Yes | No |

- | | | |
|--|-----|----|
| 3. Are vaccination education materials on walls? | Yes | No |
| 4. Is vaccination being done on date of field visit? | Yes | No |
| If "Yes": | | |
| a. correct vaccine preparation and dose? | Yes | No |
| b. correct injection technique? | Yes | No |
| c. one sterile needle and one sterile syringe used for each injection? | Yes | No |
| d. only unexpired cold vaccine in use? | Yes | No |

D. Observations, Interviews, Records

- | | | |
|--|-----|----|
| 1. Is vaccine now in the refrigerator? | Yes | No |
| If "Yes": | | |
| a. is a single person responsible for the cold chain? | Yes | No |
| b. working thermometer present? | Yes | No |
| c. temperature recorded on each of last 30 days? | Yes | No |
| d. number of last 30 days temperature in correct range (2 to 8 degrees Celsius) | | |
| e. knowledge of correct storage temperature? | Yes | No |
| f. correct placement of vaccine in refrigerator and neatly organized by vaccine and expiration date? | Yes | No |
| g. only unexpired vaccines are in the refrigerator? | Yes | No |
| h. sufficient number of full icepacks frozen? | Yes | No |
| i. sealed bottles of water in refrigerator? | Yes | No |
| j. quantity of vaccine adequate (not too little or too much)? | Yes | No |
| k. any cold chain equipment needed? | Yes | No |
| If "Yes" specify. | | |

E. Exit Interviews

Privately asked 10 women one by one as they leave the facility.

- | | Woman answers: | |
|---|------------------|--------------------|
| | <u>Correctly</u> | <u>Incorrectly</u> |
| 1. Can you tell me why we give vaccinations? | _____ () | _____ () |
| 2. Can you name 3 diseases that can be prevented by vaccination? | _____ () | _____ () |
| 3. Do you know all the diseases against which your child has been vaccinated? | _____ () | _____ () |
| 4. Does your child need any vaccinations? | _____ () | _____ () |
| 5. Where and when can your child receive his next vaccinations? | _____ () | _____ () |

F. Record any comments here:

G. Review results of this field visit with staff in charge.

1. What are strengths in their EPI?

2. What areas in their EPI need improvement?

Supervisor's Name/Title:

Signature:

Date of Visit:

Buyer's Guide to Selecting Refrigerators

For areas with:

<u>Strategy</u>	<u>Continuous 24-hour electricity available</u>	<u>at least 12 hours electricity available daily</u>	<u>at least 8 hours electricity available daily</u>	<u>electricity unreliable but gas available</u>
Static	Vestfrost MK 140 (E3/57)*	Vestfrost MK 140 (E3/57)	Vestfrost MK 140 (E3/57)	Electrolux BCW42EG(p) (E3/21)
Little outreach	Electrolux BCW 42AC (E 3/30) (1-2 teams operate daily)	Electrolux TCW 1990 (E3/62) (5-10 teams operate daily)	Electrolux BCW 42EG(p) (E3/21) (on gas) (1 team operating less than three times per week)	Electrolux BCW42EG(p) (E 3/21) (1 team operating less than 3 times per week)
Busy outreach	Electrolux TCW 1990 (E 3/62) (5-10 teams operate daily)	Electrolux TCW 1990 (E3/62) (5-10 teams operate daily)	Sibir V240 GE (E3/29) (on gas) (2-3 teams operate daily)	Sibir V240GE (E3/29) (2-3 teams operate daily)

* codes refer to listings in WMO/UNICEF Cold Chain Product Information Sheets, 1988/89.

Steam Sterilizers and Reusable Syringes/Needles

- A. Suitable for Canton Hospital giving 44 injections per day in the same room:

<u>Item</u>	<u>No.</u>	<u>P.I.S. #</u>	<u>Cost</u>
- Sterilizer Kit A	1	E 7/31	\$70.15
(single rack holds 44 syringes and 50 needles; includes sterilizer, forceps, timer, sharpening stone, soap box, and vaccine vial holder.)			
- Sterilizer syringe Kit A	1	E 7/33	23.01
(comes with all syringes/needles needed for 1 year)			
			----- \$93.16 plus additional shipping

- B. Suitable for Canton/Regional Hospital giving 88 injections per day in the same room:

<u>Item</u>	<u>No.</u>	<u>P.I.S. #</u>	<u>Cost</u>
- Sterilizer Kit B	1	E 7/32	\$84.74
(double rack holds 88 syringes and 100 needles; includes sterilizer, 2 forceps, 1 timer, 2 sharpening stones, 2 soap boxes, 1 vaccine vial holder)			
- Sterilizer syringe Kit B	1	E 7/34	41.78
			----- \$126.52 plus additional shipping

- N.B. Average cost per fully immunized child (1986 prices) is \$.0697 using reusable equipment (including syringes, sterilization, and maintenance) versus \$.0810 (syringes and maintenance).

Remember to request booklets in Spanish.

For areas with hard water (heavy load of minerals), one water filter (\$18.62) should be ordered per sterilizer. It is E 7/28 in the Product Information Chart.

Annex 11

**Model for Local Level Implementation of
the Child Survival Project***

Local level (Area) implementation of the CS project implies a process which simultaneously strengthens management capacity and extends quality preventive services to target populations. Based on experience in several provinces and general management principles, the process will probably consist of several cycles which repeat the following steps:

1. Area Health Team collects and analyzes information to define the problem (e.g. quantity and location of infant deaths, incidence of diarrheal morbidity by service unit, rate of stillbirths by parish, vaccination coverage by community).
2. Set actionable goals to change the problem.
3. Prepare an operational plan.
4. Organize the Area Health team and resources to implement the plan.
5. Monitor provision of inputs and performance of activities using available instruments of the MOH information system.
6. Supervise the quality of services based on available or specially collected information.
7. Adjustments to implementation to improve quantity and quality, including in-service training, reorganization and replanning.
8. Evaluation of plan execution and impact on the problem.

Several principles are implicit in the sequence:

- o Use of available information -- intra or extra-MOH.
- o Autonomy of the Area Health Team to set goals, restructure itself and determine resource use.
- o Operations research.
- o Repeat of the cycle reinforces learning, self confidence and autonomy.

* contributed by Dr. David Nelson, PREMI.