Public Health Practice

Action on low immunization uptake
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Immunization coverage was significantly increased in Aba, a city in eastern Nigeria, when the service was taken closer to the markets where many of the people worked.

Despite various initiatives and campaigns over the years, immunization coverage in most parts of Nigeria remains low, and this contributes to high morbidity and mortality among children. Some of the factors accounting for underutilization of the immunization service are poor transport, an ineffective cold chain, shortages of trained manpower, and inadequate community support and involvement. In many places there is a clear need for pragmatic and innovative ways of remedying the situation.

Going to the people

In Aba, a city of some 500,000 people in eastern Nigeria where a majority of the inhabitants were traders, the primary health care committee decided that immunization centres should be established in or near the main trading areas. The objective was to accommodate traders who were reluctant to leave their wares in order to take their children to primary care facilities for immunization. Traders' representatives assisted in the identification of a total of eight suitable locations for vaccination sites in three shopping centres. The local authority provided financial and political support, while the state government gave technical and logistical assistance. The project, which began in September 1990, was publicized via the traders' networks, which also helped to mobilize substantial resources for it.

A working team, comprising two nursing officers, a community health extension worker, three traders' representatives, two officials of nongovernmental organizations, and a member of staff of the local television station, was set up to review logistical matters and monitor implementation. Regular consultations were held with groups involved in planning and logistics. The views of health ministry staff were taken into consideration when the market-based immunization service was being designed and delivered.

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A health team consisting of eight nurses, four community health extension workers, four medical records officers, three health educators and three community health aides worked in the field. A mobile supporting team, including a doctor, a nutritionist and the local manager of the Expanded Programme on Immunization, visited the sites to supervise activities and attend to service users in need of medical attention or nutritional advice. Also involved were the drivers who conveyed personnel to the immunization centres, and the members of voluntary youth organizations who helped with crowd control. The local television station showed special documentaries and assisted with publicity, as did the local radio station. Information on the project was also disseminated by means of posters.

In the first instance, children and pregnant women were immunized on five working days. This was repeated after an interval of four weeks, and work continued for three months in order to fulfil the recommended schedule for triple and polio vaccines. Recipients were able to begin and complete their scheduled immunizations at the same centres. This arrangement helped to diminish irregularities in recording, minimize the drop-out rate, and facilitate the follow-up of drop-outs. Some traders declared that they would have been unable to use the immunization service had it not been brought closer to the marketplace.

The project was boosted by the input of community organizations, groups and individuals. It provided an opportunity for public and private providers to collaborate and for networking to develop. Members of community organizations, including the Boys’ Brigade, the Girl Guides and the Scout Movement, following orientation sessions with health officials, volunteered to inform parents about the immunization programme and to encourage them to update their children’s immunization status. Other voluntary bodies that contributed to the project in various ways included the Nigerian Medical Association, the Private Practising Midwives’ Association, and the Rotary Clubs. The involvement of these organizations enhanced public awareness and support and provided valuable links whereby new partnerships were developed with groups and community-based agencies eager to join in the work of promoting child health.

**Constraints and costs**

Major administrative reorganization towards the end of 1990 resulted in a loss of most of the core staff working on the project, and in uncertainty concerning its evaluation, sustainability and funding. The initial strategy had to be modified so that the service could be maintained for eligible children and mothers. The involvement of licensed private hospitals and clinics was encouraged, particularly in areas where access was difficult for government staff. Efforts to secure community involvement were intensified.

The overall cost was difficult to assess because inputs came from a range of public and private agencies. A substantial part of the private sector inputs were personal services and contacts. The cost of vaccination materials, vehicle hire and
overtime payments was around US$ 2000 by the end of the three-month period.

Outcomes

Because many trading families were reached for the first time at the special centres, coverage improved markedly for the six vaccine-preventable childhood diseases. The actual increases were from 43% to 66% for diphtheria/pertussis/ tetanus, 45% to 68% for poliomyelitis, 42% to 61% for measles, and 53% to 70% for tuberculosis. Furthermore, the project gave health workers an opportunity to deliver other services. For example, people attending the centres were taught to prepare and use salt–sugar solution for the home management of childhood diarrhoea. Advice was given on family planning, personal hygiene, sanitation and other matters.

The scheme has recently been modified with emphasis on strengthening collaboration with private health care providers in the city. One fortunate outcome of the states creation and movement of staff in the early 1990s was that it served to transplant this model of outreach immunization in the new states.

The enthusiasm of traders for the project illustrated why services should be properly responsive to the needs of users. Economic and social factors significantly influenced attitudes towards the utilization of services.

The results presented health managers with grounds for reviewing strategy on the planning and provision of public health services. It was amply demonstrated that failure to take local socioeconomic factors into account could have far-reaching consequences.

Programme organizers should pay special attention to population characteristics and other local circumstances when health needs are being assessed. If this happens there is an enhanced prospect of community involvement and participation. This is crucial if public services are to meet public expectations and the needs of users.

The people of Aba have a tradition of self-help and of collaborating with the state and local governments, and this certainly helped to make the project successful. Health workers were heartened by the public response, which they perceived as an appreciation of their dedication to the cause of maternal and child health.

The provision of health services away from established health facilities presents difficulties. Thus, for example, identifying suitable immunization sites in the three shopping complexes was a major constraint initially. However, such problems were overcome thanks to the involvement of service beneficiaries and community networks. The success of the project was a clear demonstration of the importance of providing health care services as close as possible to where people live and work.