

CARE: Training Immunizers in the Community Approach (TICA)

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Bangladesh is well-known for one of the highest rates of infant and child mortality. More than 800,000 children between age 0 and 5 years die every year. Such deaths occur primarily due to diseases like diphtheria, tetanus, pertussis, measles, poliomyelitis and tuberculosis which are all preventable through timely immunization with vaccines. The Government of Bangladesh, with the objective of reducing such high incidence of deaths, undertook a massive programme for immunization of infants and mothers throughout the country.

The Expanded Programme on Immunization (EPI) was launched by the Government of Bangladesh in 1978-79. The immunizers were located in the regional health centres, Upazila Health Complexes and Union Health and Family Welfare centres and those visiting these health centres received immunization free of cost. The results were deplorably poor. A review of the programme undertaken in 1985 showed that only 2 per cent of the target population were reached by the programme till then. It became apparent that there was a need for radical changes in the programme strategies to fulfil the Government's commitment in achieving "health for all" by 2000. Therefore, a more intensive programme was initiated in 1986.

The newly conceived programme underscored the need for an outreach strategy, demanding the immunizers to go out to the rural areas to identify the target population, and motivate, educate and immunize them. Prior to initiating the EPI activities in an area, an orientation on the EPI strategy is held in Dhaka for managers, i.e., Civil Surgeon, Deputy Director (Family Planning), etc. This orientation is followed by the training of mid-level managers on issues related to the EPI implementation, who are expected to go back to, and initiate the EPI activities in, their respective districts and upazilas. At the district level, the planning meeting is held with all the health and family planning officials and other government and non-government leaders. Subsequent to that, the planning meeting is also held at the upazila level with the upazila staff members.



Mother and child in the process of immunization

Volunteers are selected from the community to assist in the vaccination programme.

In addition to the planning meetings, trainings on social mobilisation and immunization techniques are provided to the immunizers and their union-level supervisors by the mid-level managers from the districts and upazilas. Besides, the community leaders and volunteers also receive training on social mobilisation. After the training, the volunteers and the immunizers register the prospective clients for immunization.

Following this new strategy, a pilot project was initiated in the first year. The results were extremely encouraging, prompting the planners to expand the project to another 62 upazilas in the second year. In the third phase, an additional number of 120 upazilas



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were brought under the project. Recently the programme has been expanded even further to cover the remaining upazilas, thus bringing the total coverage to 460 upazilas in the country.

CARE initiated its TICA programme in 1986-87 to assist the Government in implementing its EPI more effectively through working closely with the Government personnel at all levels. CARE's efforts were geared towards developing the competencies of the government personnel and specifically assisting in the local level planning of the EPI activities and in the training, management and supervision of the EPI staff, facilitating implementation through staff duty, assignments, logistical support, monitoring, social mobilisation and awareness-building on EPI in the target communities. Till todate, CARE has concentrated its efforts in the 96 upazilas in the southern parts of Bangladesh under the Khulna division. The programme is administered by CARE's sub-offices located in Khulna and Barisal. The project is in its third year. It is implemented by a team comprised of 1 nurse-tutor and 1 community organiser responsible for covering approximately one upazila.

Their supervisors operate at the district-level coordinating activities. During the fiscal year 1989, CARE plans to initiate its programme in the districts of Bargona, Perojpur, Narail, Bagerhat, Jhenidah, Patuakhali, Magura and Meherpur. These six districts, covered during the fiscal year 1988, will be monitored, and provided with selected inputs through a team comprised of 1 project officer, 1 community organiser and 1 nurse-tutor. CARE intends to withdraw its support in the fiscal year 1989 from the districts, where immunization first started in 1987.

From the evaluation of the TICA programme, it appears that its contributions in enhancing the effectivity of the Government programme have been significant. Within a span of only one year and a half, the coverage of the programme has expanded remarkably. While only 2 per cent of the coverage for all vaccines was noted in 1985, after one year and a half, the coverage for DPT-1, POLIO-1, and TT-1 has gone up to more than 90%. For other vaccines like DPT-11, POLIO-11, BCG, Measles and TT-11, the coverage ranges between 77 and 80 per cent. Even for the third dose of POLIO and DPT, the coverage is more than 50 per cent (see Table-1). It also appears from the evaluation that the outreach programme has contributed to a widespread dissemination of knowledge and a high degree of understanding of

the EPI. One hundred per cent of the community leaders and 95 per cent of the mothers are familiar with the EPI, and nearly three-fourths of these leaders and more than a half of the mothers could correctly identify three or more diseases against which immunization is effective. Interestingly enough, nearly three-fourths of the mothers are also aware of the number of injections. Such high degree of knowledge and awareness has been the consequence of intensive field-visits, person-to-person contacts and communications and close supervision effected by the TICA programme. It also appears that the TICA training has been immensely useful in enhancing the competencies of the EPI field personnel. Nearly three-fourths of all the trained procedures are correctly applied in the vaccination sites. What is more striking is that the involvement of the community in outreaching the clients and planning has contributed to an enhanced coverage and a decrease in drop-outs. This is indeed a significant contribution of the TICA programme.

It may be mentioned here that CARE's TICA programme provides a new direction and dimension to NGO contributions in national development. In fact, the unique feature of the programme lies in developing a sustainable health care system through enhancing the social, managerial and technical competencies of the government personnel on the one hand, and on the other, in facilitating the development of a more cohesive and effective partnership between the community and the government service providers so as to ensure high acceptability and effective participation of the beneficiaries. In fact, CARE's role provides a unique example of a development NGO whose primary function is to facilitate the development of permanent institutional structures for sustainable, people-centred development.

TICA PROJECT'S TARGET FY 90 THROUGH FY 92

The project will work jointly with MOHFP (EPI) in 896 unions in 16 districts in Khulna Division.

Technical skills of the MOHFP staff will be enhanced on immunization and MCH-FP service delivery through outreach sessions and on



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social mobilization techniques. The total number of MOHFP personnel trained will be :

- Mid-level managers at district and upazila : 438.
- Field-level H&FP staff (HA, FWA) : 5376.
- Union-level H&FP Supervisors (AHI, FPA) : 1792. The number of community volunteers trained : 18,792. Each month, these trained personnel will conduct 10,752 outreach immunization and MCH-FP sessions for :

- 322,560 rural mothers
- 161280 children under 1.

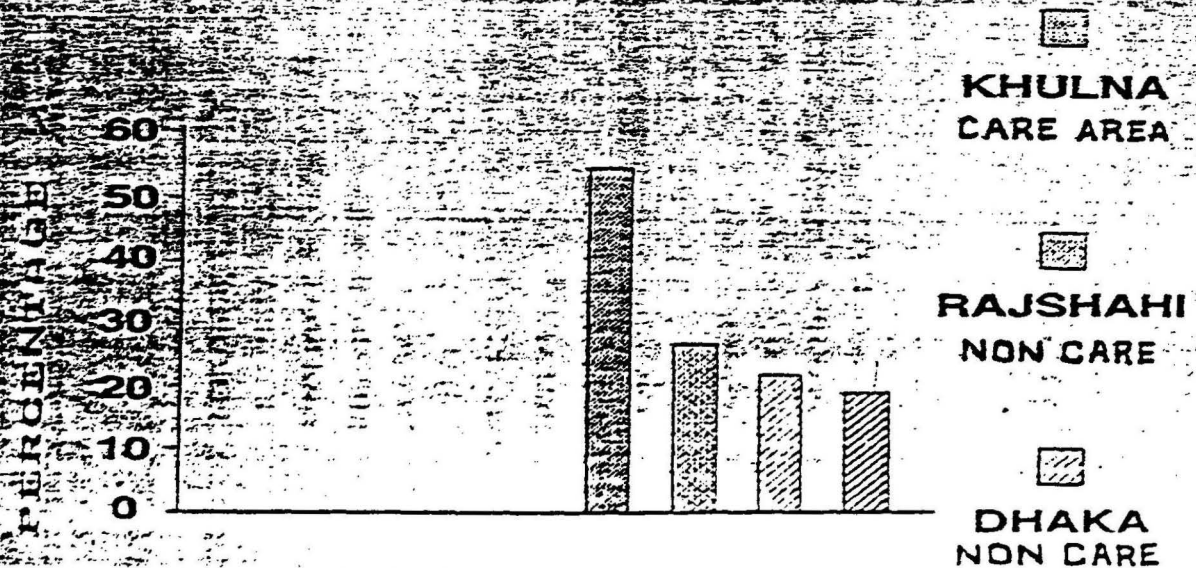
The following services will be made available at outreach sessions by the trained MOHFP field staff :

- 1) Immunization against vaccine preventable diseases. (Tetanus, Diphtheria, Measles, Whooping cough, Tuberculosis, Poliomyelitis)
- 2) Women group education on MCH-FP topics.
- 3) Provision of ORS packets.
- 4) Provision of Vitamin A capsules.
- 5) Ante and post-natal examination (advice and referral).

- 6) Provision of non clinical contraceptives (oral pills, condoms)

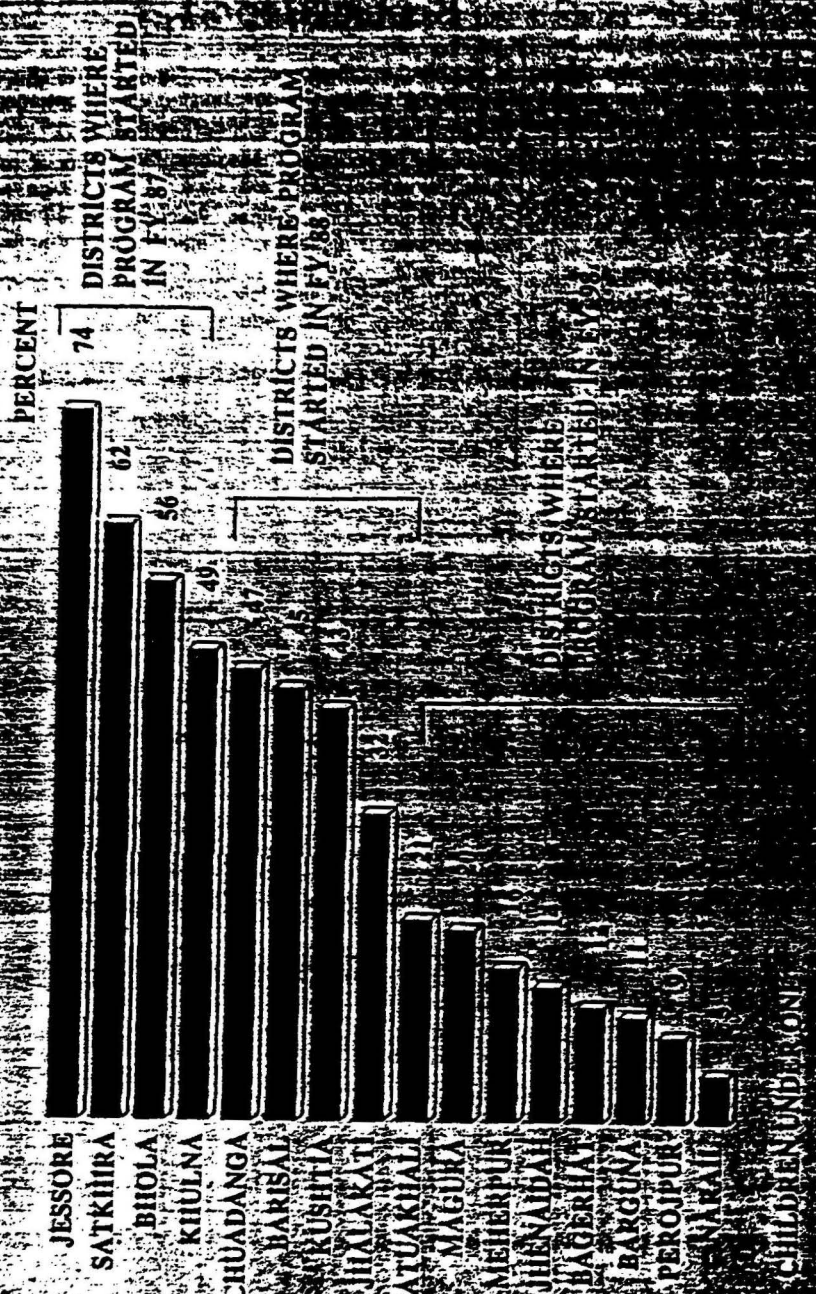
The project will promote various social mobilization activities at the village level in order to increase mothers' participation in outreach immunization and MCH-FP sessions.

DPT-3 IMMUNIZATION COVERAGE COMPARATIVE DATA IN BANGLADESH CARE & NON-CARE AREAS



**COMPARISON OF DISTRICTS IN KHULNA DIVISION
(DPT-3)**

JULY 1988-JUNE 1989



Prevention of night-blindness in rural Bangladesh

SIR—Chronic dietary deficiency of vitamin A and its overt symptoms, including blindness, have been known for over two decades in Bangladesh. A recent survey found deficiencies almost four times larger than that indicated by the World Health Organization as constituting a major public health problem (1); the prevalences of night-blindness and Bitot's spots in rural Bangladeshi children were 3.6% and 0.9% respectively. Of the country's 23 million children in the age range of 6 months to 6 years, approximately one million can be assumed to have clinical signs of vitamin A deficiency. Over 60 000 children under 6 years of age suffer some degree of permanent loss of sight due to a lack of vitamin A. Almost 100 children are going blind each day, more than half of them dying within a few weeks (1).

Bangladesh has abundant supplies of foodstuffs rich in carotene, the precursor of vitamin A, such as dark green leafy vegetables and yellow fruits, but too few of these are consumed, particularly by children. In 1973 the government started distributing capsules containing 200 000 IU vitamin A to children every six months. The average coverage was 46% but the children of poor, landless and relatively inaccessible families were not reached and the deficiency rate remains alarmingly high (2).

In another recent study, in-depth interviews and focus-group discussions were conducted with 140 people representing a cross-section of age, sex,

religion, education and economic background in eight villages of central and northwestern Bangladesh, with a view to exploring perceptions about night-blindness (3). The condition was clearly recognized by the people, who correctly described its symptoms. Diarrhoea was mentioned by many as a cause of night-blindness, while some others related it to vitamin A deficiency, although vitamin A was specifically mentioned by only a few. The people knew vitamins as medicines and considered them to be a source of strength. Many maintained that night-blindness occurred mostly in children and pregnant women, whereas many others thought that males and poor people were particularly susceptible to it.

Village practices for the treatment of night-blindness conformed to the modern approach. They included the feeding of animal liver, *shak* (a dark green leafy vegetable), and the small fish *mola* and *dhela*, which contain very high amounts of vitamin A (4). People thought that there was a medicine for the treatment of night-blindness, and, interestingly, their description of it was suggestive of vitamin A capsules. When asked about the sources of this medicine, the government or, in a few cases, the Bangladesh Rural Advancement Committee, a non-governmental organization, were mentioned.

The question remains as to why so many children continue to suffer from vitamin A deficiency. Although *shak* and fish rich in vitamin A were mentioned as being good for night-blindness, they are not given to young children, or are given only in minute doses (5), since these foodstuffs are considered difficult for children to digest. They are also portrayed as reflecting poverty and consequently tend to be unpopular. Furthermore, cooking methods destroy a large amount of carotene.

In 1985, UNICEF supplied 81 million vitamin A capsules to Bangladesh and Indonesia, but their distribution was badly managed in some areas. Government health workers did not know at what age the capsules should be given, and in a discussion meeting maintained that they could be supplied to any person and in any number. In a focus-group discussion with adult males, one man reported that he took 17 capsules in two days,