TRAINING AND IMPLEMENTATION PLAN

Integrated Health Training Package for Hard to Reach Settlements, Nigeria

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1. INTRODUCTION

According to the *Polio Eradication & End game Strategic Plan 2013-2018*, all wild poliovirus transmission must be stopped globally, including in Nigeria, by the end 2014. In order to achieve eradication, polio immunity gaps must be rapidly closed in the high-risk states, including in remote, hard-to-reach communities where regular immunization activities may not consistently reach, and poliovirus transmission may occur undetected. In particular, in northern Nigerian communities that face additional health risks due to low access to routine immunization, malaria, pneumonia and diarrhea amongst children, poor nutrition and high maternal illness and death. Barriers to prevention and treatment in hard-to reach communities include distance or lack of funds to reach health facilities that are poorly stocked and staffed, cultural barriers, social exclusion, or security risks.

2. SITUATION ANALYSIS

Several data sources reveal that polio immunity gaps remain, including in hard-to-reach areas.

Overview

In 2013, Nigeria recorded 53 wild polioviruses (WPV) in 9 states, and 5 circulating vaccine-derived polioviruses (cVPDV) in Borno and Adamawa. The states recording the most polioviruses are Borno (17 WPV and 3 cVPDV); Kano (15 WPV); Yobe (8 WPV) and Bauchi (6 WPV), representing 87% of WPVs in Nigeria in 2013. Kaduna and Katsina were centres of poliovirus transmission in 2012 with 15 and 34 wild poliovirus cases respectively of the 129 recorded in Nigeria. In 2013, Kaduna recorded 2 polio-compatible cases, and Katsina recorded five – indicating potential transmission in each of these states. About half of these cases were found in poor, rural, hard-to-reach families and non-compliant urban slums, and about one-third of the cases were under-immunized (< 3 doses of oral polio vaccine), demonstrating the need to accelerate identification and immunization of zero-dose and under immunized children.

Current Health Data

Nigeria has amongst the highest newborn (78/1,000), child (124/1,000) and maternal mortality (545/100,000) in the world. Approximately 40% of children under five are stunted, 14% wasted, and one quarter are underweight. For each of the indicators, the rates are as much as twice as high, or even more, for the states in the northern zones. Of under-5 deaths, more than 50% are caused by pneumonia, diarrhea and malaria. Nigeria has the second highest number of child deaths from diarrhea and pneumonia in the world (231,000), the highest number of child malaria deaths (143,000). Neonatal deaths account for about 200,000 deaths per year. Other infections, including those prevented by currently available vaccines such as meningitis, pertussis and measles, cause 15% of under-five deaths. Access to prevention and treatment is limited. For examples, in cases of diarrhea, only 25% of children receive oral rehydration therapy, and less than 1% receive zinc. Less than a quarter of children with suspected pneumonia receive antibiotics.[1] About 16% of children under five are sleeping under insecticide treated bed nets, and use of the recommended artemisinin combination therapy to treat malaria is very low.

Malnutrition amongst women of childbearing age is significant and ranged from almost 9% of women in Kebbi to 16% in Yobe. Under-five Vitamin A supplementation coverage has been low, and recently released preliminary results of the 2013 Demographic Health Survey shows that only about a third of women's last births in Bauchi, Borno and Yobe were protected against neonatal tetanus, less than 10% of children aged 12-23 months had received all basic vaccinations in Borno, Yobe and Bauchi, and just 13% had in Kano 35.3% had in Kaduna and 8.7% in Katsina.

[1] Nigeria: *Essential Childhood Medicines Scale-up Plan* (2011)

Hard to Reach Communities

In the Nigerian contact, hard to reach groups can occur due to rural, urban, security issues and socio-economic factors. Rural can be defined as people living too far from health centres or obstructed by geographical barriers making their locations difficult to access due to poor terrain, geographical obstacles (rivers) and poor/or no road networks. Urban can be defined as people living in urban areas close to health centres but lack interest in health services. Resistant groups are people not interested in health services due to social, economic, or political reasons that may prevent them from seeking services. Resistant groups can be influenced by misconceptions, religion, cultural and traditional beliefs. Resistance can also be caused due to mistrust in the health service with doubts on safety of the vaccine and the service providers, lack of adequate information on the benefits of immunization and good health seeking practices.

Reaching the hard-to-reach can take a substantial amount of time, sometimes several hours just to reach one community and long distances to travel in extreme hot temperatures. Given the need to access hard-to-reach communities with the polio vaccine, the time and resources required to get there, and the serious additional health needs in these areas of Nigeria, UNICEF in collaboration with WHO proposed to bring a larger package of basic health services to these communities, that will deliver basic child and maternal health services, together with general primary health care services. This will require a standard kit of child health interventions (oral rehydration salts, zinc, antibiotics, malaria treatment, deworming, and vitamin A); maternal health interventions (malaria prevention, deworming, iron and folic acid supplements) and community health interventions (for scabies, eye and ear infections). The composition of the kit is based on known maternal, child and community health conditions, according to published data.

Volunteer Community Mobilizer (VCM)

A Volunteer Community Mobilizer, is a popular woman in a settlement, with very basic training knowledge in primary health care, who is able to carry out tasks such as mobilizing the caregiver through interpersonal communication by conducting house to house visits, inform the community on health campaigns, recording and tracking newborns, linking children to facilities for routine immunization, undertaking AFP and surveillance for other diseases offering basic water and sanitation information, and advising pregnant women to get antenatal care. A VCM already provides basic outreach with oral polio vaccine in between polio campaigns, including in hard to reach areas.

Community engagement is important for the promotion of basic health care. In this context, it is critical for the community to understand the purpose of the mobile outreach sessions, and to demand for the services. Engagement activities can include orientation and involvement of the community leaders, and involving community members to mobilize the settlement populations for outreach sessions. This will be coordinated through LGA and cluster level communication consultants that UNICEF has in place who support polio and routine immunization in the LGAs, and Volunteer Ward Supervisors (VWS) that work directly with VCMs whose role will be scaled up in the implementation areas to ensure strong community linages and engagement, and promotion of better health practices.

3. TRAINING AND CAPACITY BUILDING

Given the urgent need to raise immunity levels and stop polio transmission in hard to reach communities that have existing health challenges, an integrated training curriculum package will be developed to train VCMs and other community mobilizers on IPC technical skills on essential maternal and child health interventions.

Output

Conduct a 3-day training workshop for VCMs and other community mobilizers on the technical components of the integrated health package (including data tools, reporting, feedback, and a roll-out plan to cover their personal timeline, monitoring, and assessments).

Outcomes

1. Increased knowledge and skills of VCMs and other community mobilizers on maternal and child health interventions.
2. Increased coverage of basic maternal, newborn and child primary health care interventions in the hard-to-reach communities.
3. Increased number of VCMs and other community mobilizer's trained to promote key health messages, improved IPC skills, usage of data tools, planning and reporting.

Goals

Polio transmission is stopped through increased poliovirus immunity in children under five years of age, and increased knowledge and use of essential child and maternal health interventions in hard to reach communities.

4. INTEGRATED TRAINING PACKAGE

An integrated training package will be developed consisting of modules on nutrition, WASH, clean delivery, polio, routine immunization, child protection, surveillance and record keeping.

Collaboration and Partnerships

For the development of the training programme, interviews and collaboration were conducted with: UNICEF Nigeria Country Office (WASH, Nutrition, C4D, Polio, External Communications, Deputy Representative, Communication for Development – Polio, Health, Child Protection, UNICEF New York, Polio Division, WHO (Nigeria Office) and the National Primary Health Care Development Agency (NPHCDA).

Settlement Locations

The settlements will be pre-selected in hard-to-reach areas in Bauchi, Borno, Kaduna, Kano, Katsina, and Yobe States. Two States, Kaduna and Katsina, will be fully implemented by UNICEF where the VCM network is already operational in the hard to reach areas for polio. An additional 800 VCM will be brought on board to cover the remaining hard to reach locations. UNICEF will work in close partnership with WHO to provide support to the remaining 4 States, and where a VCM network is not present, WHO will bring in 2 Community Engagers.

Pilot Test

The integrated health package will first be piloted in Kaduna and Katsina States. After review of the training curriculum, revisions will be made for scale-up in the remaining states.

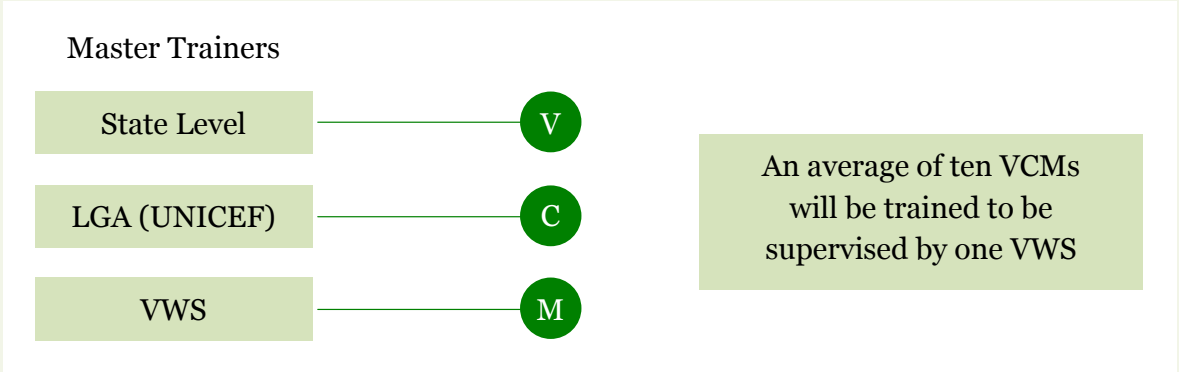
Training Curriculum Development

A two-step training programme will be implemneted:

1. Training of Trainers (TOT) on the intergrated health package (LGAs, Consultants, and Volunteer Ward Supervisors, VWS). The TOT traiing will also consist on a module on monitoring and supervision, and mentoring skills and on the job training of VCMs for ICCM – will make contacts with the VCM 4 x a year for observation.
2. Training of VCMs and other community mobilizers on the intergrated health package, and devleopment of their self-help groups (guidelines).

Target Training Audience

To increase the knowledge and capacity of VCMs and other community mobilizers, on selected integrated training modules:



Training Protocol Plan

1. Develop a technical working group (Country office programme sections, and HQ).
2. Review existing IEC materials and training manuals.
3. Develop an integrated training curriculum.
4. Develop a timeline, training roll-out plan and monitoring tools for the training curriculum.
5. Pilot pre-test the training curriculum before scale-up.

Training Modules

No.	Module	Recommended topic
1	Nutrition (confirm what commodities will be taken to the hard to reach communities)	Screening and referrals Follow-up of defaulters Signal signs of malnutrition for mothers Key messages – (include vitamin A, nutrition during pregnancy) IYCF counseling (also growth promotion and development) Deworming Vitamin A if not received (part of package)
2	WASH	Good sanitation – health risks (use of latrines) Hand washing (key messages before and after) Interlinking hygiene with polio
3	Maternal Health (1 -2 key messages on ANC) focus on messages given to you.	ANC messages should still be in here but not to overshadow the main messages below. Do not overload them due to learning capacity key messages are most important. ANC – provide clean delivery kits and explain contents and benefits and promote institutional deliveries PNC- home visit right after delivery 24-48hrs. Target is to ensure cord care is being undertaken and no complications are occurring PMTCT – will be state specific (burden of HIV)? Will be done with ANC
4	ICCM	Pneumonia Diarrhea (including ORS) Malaria
5	Routine Immunization	Child routine vaccines Interlinking polio with RI
6	Polio (to include IPV)	Key messages Surveillance
7	Child Protection (Naureen will follow-up)	Birth registration
8	Monitoring/recording	Data collection and tally sheets, SMS platforms

Tentative Day Schedule

Day 1	Day 2	Day 3
**MNCH- Maternal health and ICCM (malaria, diarrahea pnemonia)	(RI, polio) WASH / Nutrition	Data Collection Using of data tools Using mobile multi-media to support messaging
Lunch Break	Lunch Break	Lunch Break
MNCH continued Protection – birth registration	IPC – skills only (with use of tools, role play, etc.)	Supervision Work-plan development and roll-out

** Trainings should be message specific for VCMs due to retention capacity. Review the ICCM Government of Nigeria document and focus on the key issues.

Day 3 Work Plan Development

Supervisor's Day 3	VCMs Day 3
Development of work plan Monitoring and supervision (work plan) Multimedia reporting key messaging Mentoring skills	Development of work-plan Supervision – self-help group Discussion of SMS platforms and voice messages

Methodology

The methodology of trainings will be based on "learning by doing" in which highly interactive sessions will be designed for each topic. There will be minimal use of lectures and more group interactions, role-plays, storytelling etc. A facilitators meeting will be organized one day before the start of training to finalize sessions and methodology.

Timeline (Refer to Annex 1)

The tentative timeline for the first integrated training is scheduled for the last week of May 2014. For TOTs in Kaduna and Katsina states.

Checklist

1. The Develop a technical working group (Country office programme sections, and HQ) (Naureen, Lorraine)
2. Review existing IEC materials and training manuals (Lorraine)
3. Develop an integrated training curriculum (Lorraine)
4. Develop a time line, training roll-out plan and monitoring tools for the training curriculum (Lorraine/Naureen)
5. Pilot pre-test the training curriculum before scale-up. (First pilot: Kaduna and Katsina)
6. Development of training and implementation plan (Lorraine)
7. Development of communication plan (Naureen)
8. Training schedule – (meeting of facilitators)
9. Operational logistic checks (to be broken down and checked every Monday) Naureen
10. Competed inputs into M and E framework (Lorraine and Naureen)

Training Aids

- The Training curriculum (training manual for TOTs, data tools supervisory checklist) to be designed at HQ.
- Logistic checklist (Make sure commodities required are available)
- Flip book (already developed – check on quantities are re-ordering)
- Training videos via phones (for use further down)
- Visual aids for the VCMs IIEC materials: (poster – polio stages, laminated child photo, health poster – correlation – WASH, nutrition, diarrhea, etc.).

M and E Framework

- The Inputs to be completed by 30th April 2014
- Learning Process: Increased number of VCMs and other community mobilizer's trained to promote key health messages, improved IPC skills, usage of data tools, planning and reporting.
- Communication Process: # of house to house visits planned and conducted, number of newborns documented

Operational Logistics

- Checklist of kits – TBD (Naureen). To be completed by the Nigeria Country Office.

No Pre-testing and approval of Key Messages

- All key messages have already been approved for use by UNICEF CO.
- The first pilot training will be the pre-test and will be conducted in Katsina and Kaduna States.

ANNEX

Timeline

APRIL						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
20	21	22 Training plan final draft (LSH)	23	24 Training plan final draft (LSH)	25	26
27	28	29	30 Feedback on review of IEC (LSH) Final M and E framework inputs	1 May	2 May	3 May

MAY						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
4	5	6	7	8	9 First curriculum draft due (LSH)	10
11	12	13	14 Draft monitoring and supervisory tools and logistic checklist (NN, Noah, Godfrey)	15	16	17
18	19 Final tools available (NN)	20	21	22	23 Final curriculum before printing	24 Campaign
25	26 Prepared for first trainings	27	28	29	30	31