NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

NATIONAL IMMUNIZATION POLICY

REVISED 2009

Plot 681/682 Port Harcourt Crescent, Off Gimbiya Street, Area 11, Garki Abuja, FCT

LIST OF REVIEW COMMITTEE MEMBERS

Dr. E. A. Abanida	NPHCDA, HQ., Abuja
Dr. C. Mamman	NPHCDA, HQ., Abuja
Dr. Adamu Nuhu	NPHCDA, HQ., Abuja
Dr. Nosa Owens-Ibie	WHO, Abuja
Mrs. Halima Tajo	NPHCDA, HQ., Abuja
Pharm Inuawa Ya'u	NPHCDA, HQ., Abuja
Mallam Abdulrahahman Yakubu	SMOH Kano
Dr. M.O. Ibrahim	GAVI Consultant, NWZ
Pharm. M.S. Adamu	NPHCDA, NCZ
Dr. H. B. Pariya	SMOH, Yola
Dr. E. Dede	WHO, Abuja
Mallam A. G. Mohammed	WHO, Abuja
Dr. Jane Bammeke	UNICEF, Abuja
Dr. Felix Akhibi	UNICEF, Abuja
Dr. Bassey Okposun	NPHCDA, SSZ
Prince John. D. Egbe	SMOH, Yenagoa
Dr. Kehinde T. Craig	EU-PRIME
Dr. Sokoya 'Sola	SMOH, Lagos
Pharm. (Mrs.) Bello-Osagie	GAVI Consultant, SSZ
Mallam Tanimu L. Marafa	NPHCDA, HQ., Abuja
Dr. A. Etsano	NPHCDA, HQ., Abuja
Dr. Avuwa J. Oteri	NPHCDA, HQ., Abuja
Alh. Madiu Haruna	Fed. Min. of Finance
Pharm. Gloria Amaka Nwoha	NPHCDA, HQ., Abuja
Ojeah Jacob	National Planning Commission, Abuja
Dr. I. O. Yisa	EU-PRIME, Abuja
Dr. Ben. Ayene	PRINNN/DFID, Abuja

Abbreviations & Accronyms

AEFI:	Adverse Events Following Immunization
BASICS:	Basic Support for Institutionalizing Child Survival
COMPASS:	Community Participation for Action in the Social Sector
CSM:	Cerebro-spinal Meningitis
DPT:	Diphtheria, Pertusis and Tetanus
DSNO:	Disease Surveillance and Notification Officer
EPI:	Expanded Programme On Immunization
FMOF:	Federal Ministry of Finance
FMOH:	Federal Ministry of Health
IMMUb:	IMMUNIZATION basics
HBV:	Hepatitis B Vaccine
LGA:	Local Government Area
MDGs:	Millennium Development Goals
NGO:	Non-Governmental Organization
NPC:	National Planning Commission
NPHCDA:	National Primary Health Care Development Agency
OPV:	Oral Polio Vaccine
PHC:	Primary Health Care
REW:	Reaching Every Ward
SIA:	Supplemental Immunization Activities
SMOH:	State Ministry of Health
TT:	Tetanus Toxoid
UNICEF:	United Nations Children's Fund
UNS :	United Nations Systems
USAID:	United States Agency for International Development
WHO:	World Health Organization
YF:	Yellow Fever

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FORWARD

Nigeria is a signatory to the declaration on the survival, protection and development of children, which was articulated at the 49th World Health Assembly in 1988. This was further reinforced by the World summit for children held in New York in 1990. This declaration established challenges for global immunization.

The Federal Government of Nigeria through the Federal Ministry of Health has pursued an active immunization programme, and has given necessary priority to its immunization programme. The Expanded Programme on Immunization (EPI) was initiated in 1979. However, in view of the critical need to enhance the effectiveness of immunization, which was fast declining, and to meet the global challenges of immunization, the EPI was restructured in 1997. It was renamed National Programme on Immunization (NPI) and established as a Parastatal of the Federal Ministry of Health by decree 12 of 1997.
Following the Federal Government Health Sector Reform, NPI was merged with the National Primary Health Care Development Agency (NPHCDA) in May 2007,

The NPHCDA is now charged with the responsibility of effectively controlling, through provision of vaccines and immunization guidelines, the occurrence of the following diseases: Tuberculosis, Poliomyelitis, Diptheria, Pertussis, Neonatal Tetanus, Measles, Yellow Fever, Hepatitis B, Haemophilus influenzae type b, Cerebro-Spinal Meningitis (CSM), Pneumococcus, Rotavirus, Human Papilloma Virus (HPV) and other vaccine-preventable diseases as epidemiological evidence may deem necessary.

In Nigeria, all three levels of government (Federal, State and Local) are important partners, committed to the formulation of strategies and support for the implementation of an effective immunization programme.

This document is a revised version of the 2003 edition; the document provides guidelines on injection safety, standards and specifications, Adverse Events Following Immunization (AEFIs) and the Reaching Every Ward (REW) approach. Also, highlighted are the national focus on strengthening of surveillance systems, advocacy and social mobilization, and private sector collaboration. The document is expected to have a boosting effect on EPI in the provision of an effective, and sustainable immunization service which is community driven, operated and owned.

Prof. Babatunde Osotimehin (OON)
Hon. Minister of Health
Federal Republic of Nigeria

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Dr Muhammad Ali Pate
Executive Director/CEO
National Primary Health Care Development Agency
Abuja

CHAPTER ONE:

1.1 Preamble

It is the policy of the Federal Government of Nigeria to provide immunization services and potent vaccines free to all population at risk of vaccine preventable diseases. This is achieved through the NPHCDA, other tiers of government and stakeholders by pursuing the following goals and objectives:

2.2 Goal/Objectives

The main goal and objective is to develop and promote immunization programmes geared towards reduction of childhood morbidity and mortality through adequate immunization coverage of all at-risk populations

The Federal Government shall pursue all strategies in conjunction with all tiers of Government to:

i. Improve and sustain routine immunization coverage of all antigens to 90% by the year 2020 in line with the National Vision.
ii. Achieve through quality supplemental activities, interruption of polio transmission by the end of 2009 and total eradication by the end of 2013)
iii. Eliminate maternal and neo-natal tetanus by the end of 2010

The Government through the FMOH in collaboration with the National Primary Health Care Development Agency shall also effectively put in place annual plans to prevent, detect, control and eliminate the occurrence of out-breaks of CSM, Measles, Yellow fever and any other VPDs in all parts of the country

2.3 Target Groups/eligibility for Immunization

In pursuit of national interests and priorities, the government shall provide vaccines and immunization services free to all eligible populations, through functional PHC centers government and private health facilities. Government shall ensure the provision of vaccines and the use of a national immunization schedule in order to attain optimal protection against childhood killer diseases and other vaccine preventable diseases for:

i. Eligible children 0–11 months
ii. Eligible children 0-59 months
iii. Women of child bearing age 15–49 years
iv. Other at-risk groups especially in out-break situations and those traveling to endemic areas.
iv. International travelers

No eligible person shall be denied immunization unless there are medical contraindications as stated in the standard of practice.

2.4 Vaccines and Vitamin A

The following vaccines are included in the EPI schedule of vaccinations.

2. 4.1 Traditional Routine Immunization Vaccines

i. Bacille-Calmette Guerin (BCG)
ii. Oral Poliomyelitis Vaccine (OPV)
iii. Diphtheria, Pertussis, Tetanus (DPT) Vaccine
iv. Measles Vaccine
v. Tetanus Toxoid
vi. Yellow Fever Vaccine
vii. Hepatitis B Vaccine
viii. *Cerebrospinal Meningitis (CSM) Vaccine
ix. **Vitamin A

NOTE:
* Please note that CSM is not one of the traditional vaccines, but included in the list because it is given through vaccination. It also has implications for the cold chain system
** Vitamin A is included in the list as a way of integrating it with vaccination schedule .

2.4.2 Supplemental/ catch–up campaigns vaccines

i. Oral Polio Vaccine (for polio eradication)
ii. Tetanus Toxoid (for maternal and neo-natal tetanus elimination)
iii. Measles vaccine (for accelerated measles campaign)

2.4.3 Vaccines for out-break control and special groups

i. CSM Vaccine (for control of CSM out break and travelers to endemic areas)
ii. Yellow fever vaccine

2.5 Immunization Schedule

The schedule is designed to include all children 0-1 years who shall receive one dose of BCG, one dose of Yellow Fever vaccine, 3 doses of DPT, 3 doses of Hib vaccines, 3 doses of Hep.B vaccines 4 doses of OPV and one dose of Measles vaccine before the age of one . There shall also be a separate schedule for women of childbearing age (WCBA).

In addition newer vaccines and technology shall be introduced into the schedule for children and other at risk age groups based on the country decision to add such vaccines to the schedule
The schedule also provides the immunization against CSM. However, this shall be available only to contain out-breaks in high-risk populations. The table below shows the approved immunization schedule for children less than one year.

Table 1. ***Immunization Schedule for Children Under One Year***

Contact	Minimum Target Age Of Child	Type Of Vaccine	Dosage	Rout of administration	Site
1st	At birth	BCG	0.05ml	intra dermal	RT. Upper Arm
		*OPV0	2 drops	Oral	Mouth
2nd	6 weeks of age	Pentavalent1 (DPT, HBV and Hib)	0.5ml	intra muscular	Antero- lateral aspect of thigh
		OPV1	2 drops	Oral	Mouth
3rd	10 weeks of age	Pentavalent2 (DPT, HBV and Hib)	0.5ml	intra muscular	Antero-lateral aspect of thigh
		OPV2	2 drops	Oral	Mouth
4th	14 weeks of age	Pentavalent1 (DPT, HBV and Hib)	0.5ml	Intra- muscular	Antero-lateral aspect of thigh
		OPV3	2 drops	Oral	Mouth
5th	9months	Measles	0.5ml	Subcutaneous	Left upper arm
		Yellow Fever	0.5ml	Subcutaneous	Left upper arm

**OPV0 must be given before the age of two weeks; **Monovalent vaccine*

Table 2: **TT Immunization schedule for women of childbearing age**

DOSES	WHEN TO GIVE	EXPECTED DURATION OF PROTECTION
TT1	At first contact or as early as possible in pregnancy	None
TT2	At least 4 weeks after TT1	1-3 years
TT3	At least 6 months after TT2 or during subsequent pregnancy within 3 years.	5 years
TT4	At least 1 year after TT3 or during subsequent pregnancy	10 years
TT5	At least 1 year after TT4 or during subsequent pregnancy	All the childbearing years

***Recommended Schedule for Children with HIV-Infection/AIDS**

VACCINE	ASYMPTOMATIC HIV INFECTION	SYMPTOMATIC HIV INFECTION	OPTIMAL TIMING OF IMMUNIZATION
BCG	YES	NO	At birth
DPT	YES	YES	6, 10, 14 weeks
OPV*	YES	YES	0, 6, 10, 14 weeks
MEASLES	YES	YES	9 months
HEPATITIS B	YES	YES	As in uninfected children
YELLOW FEVER	YES	NO	9 months
Hib vaccine	YES	YES	6, 10, 14 weeks
TETANUS TOXOID	YES	YES	5 doses as in uninfected women

****Note: BCG, Mumps and Rubella are contraindicated***

The immunization status of every child should be checked at each contact with a health service (including hospital outpatient departments and doctor's surgeries) and immunization should be offered as appropriate.

2.6 Supplemental Immunization Activities (SIAs)/ Catch-up Campaigns

SIAs / Catch-up campaigns (IPDs, LIDs, Child Health Week etc) shall be planned and regularly carried out based on needs and result of coverage surveys, to improve routine immunization coverage and control out-break situations e.g. Meningitis, measles, and yellow fever Similarly, supplemental TT, activities for women of childbearing age ,Polio Eradication and Measles Elimination activities shall be planned and carried out annually until the goals/objectives are met.

2.7 Immunization Facilities/Centers

The National Primary Health Care Development Agency shall make available potent vaccines that are bundled in all designated government (PHC centers, secondary and tertiary institutions) and collaborating private health institutions..

2.8 Private Sector Involvement

In order to increase private health facilities participation, Government shall:-

1. Supply vaccines free to all collaborating private health facilities
2. Support individuals and organizations operating private health facilities in underserved population with the provision of minimum cold chain equipment to ensure delivery of potent vaccines.
3. Make available all data tools (registers, tally sheets, child health and personal health cards etc.) to private facilities for proper documentation of vaccination.
4. Encourage institutions who so desire, to print cards with their institutional activity to do so using NPHCDA prototype.
5. Enforce regular statistical returns preceding collection of vaccines.
6. Support regular capacity building to all service providers at all levels.

2.9 Research

Government shall encourage and finance research to provide data to guide activities designed to ensure high EPI coverage and sustainability especially in areas of epidemiology of EPI target diseases, accurate planning and vaccine forecasting, social mobilization, and monitoring and evaluation.

2.10 New Vaccines &Technologies

Government shall monitor progress in vaccine technologies and ensure inclusion of new vaccines and other technologies that have been demonstrated to be effective and are relevant to national needs in the EPI.

2.11 Financing Immunization

The funding of immunization services shall be a collective responsibility of all tiers of government. The following sources of funds shall be explored for the financing of immunization services on a sustainable basis:

i. Statutory budgetary allocation from the Federal, State and Local Government Areas
ii. Promotion of private sector funds mobilization, e.g. Nigerian Immunization Fund (NIF) managed by reputable financial institutions in Nigeria and the involvement of established NGOs, Rotary International and non-traditional immunization partners in the organized private sector.
iii. External donors: development partners e.g. World Bank, European Commission, United States Agency for International Development (USAID), Canadian Agency for International Development (CIDA), Japan International Cooperation Agency (JICA), U.K. Department for International Development (DFID), World Health Organization (WHO), the United Nations Children's Fund (UNICEF), Global Alliance for Vaccines and Immunizations (GAVI) and friendly foreign governments.
iv. Promotion of innovative ways for community participation to enhance community ownership of the immunization programme.

CHAPTER TWO

2 INJECTION SAFETY

3.1 Preamble

The safety of injections, including the proper disposal of used injection equipment, is of primary concern in ensuring the well being of people receiving therapeutic injections, immunization injections, or injections for other purposes. Injection safety must be a concern for both public and private health institutions.

3.2 Policy statement

The Federal Ministry of Health through the NPHCDA shall pursue the policy that vaccinations, which require injections, given in public and private health institutions should be by qualified health personnel and must be safe. It means that every injection be given using a single sterile syringe and needle combination, which is then safely disposed of after use.

3.3 Acceptable equipment for injections

The following equipment types are acceptable for injections:

3.3.1 Auto-disable disposable syringes (plastic)

- These syringes are the safest and easiest injection equipment. All injectable vaccines should continue to be administered using Auto-disable syringes.
- The Federal government shall ensure the provision and availability of acceptable equipment for injection.(AD syringes and safety boxes)

The provision of safety boxes for disposal of used syringes shall be mandatory.

3.4 Disposal and Destruction of Used Injection Equipment

3.4.1Safe Disposal of Injection Equipment

- All used injection equipment must be safely disposed off.
- All disposable syringes and needles, including auto-disable equipment, should be disposed of immediately following use in a designated safety box or sharps puncture-proof container.
- The needle should not be recapped or removed from the syringe; the whole combination should be inserted into the safety box directly after use.
- A system for tracking the distribution, utilization and destruction of injection equipment should be introduced.
- Additional waste from injections (cap, syringe packaging, cotton wool) should be disposed of appropriately away from harm

3.4.2 Methods of Disposal

- The method of choice for destruction of filled safety boxes is incineration, preferably in an appropriate high-temperature incinerator (> 800°C).

- If such an incinerator is unavailable, a low-temperature incinerator (300-400°C) may be used.

- Alternatively, appropriate burn and bury method should be used to destroy filled safety boxes (limited to area with no surrounding population).

- Residue from incineration (oxidized needles, vials, etc.) should be safely removed and properly buried in an appropriate pit.

3.5 Training

1. All health workers, including those in the private sector, shall be exposed to the principles of injection safety.
2. Provision shall be made for in-service training of currently existing health workers.
3. Formal training curricula for physicians, pharmacists, nurses and other categories of health professionals should be revised to include appropriate instruction and materials on injection safety.
4. Government shall ensure continuous training in relevant areas for health workers

3.6 Management

In order to ensure that injection safety activities are carried out properly it is imperative that trained and competent personnel at all levels of the health system are identified to monitor and manage injection safety issues, including the safe disposal and destruction of used injection equipment. Management issues include health staff training and supportive supervision of practices, equipment requirement calculation, budgeting and monitoring.

The status of injection and disposal safety shall be regularly assessed in order to identify the problems and the areas to be improved upon (introduction of new equipment and technologies like auto-disable syringes and incinerators).

3.7 Public Awareness

The public has a right and a responsibility to know about injection safety issues. Health workers are expected to inform their clients of the need for injection safety and the consequences of unsafe injections.

The Ministry of Health, in partnership with other concerned ministries (e.g., the Ministry of Environment), shall accept the role of an advocate for promoting injection safety issues within the country, and identify priority target groups and strategies for dissemination of messages.

CHAPTER THREE

3 VACCINE STORAGE AND DISTRIBUTION

The government of the Federal Republic of Nigeria is committed to the strengthening of immunization services whereby immunization shall be available to all eligible persons attending vaccination sites. For vaccines to be potent, they have to be stored and transported at appropriate cold temperature in line with W.H.O standard. This ensures that vaccines when used can achieve the desired effect.
Consequent on this, the government shall undertake the provision of potent vaccines at strategic places.

3.1 Storage:

Storage of vaccines requires that the cold chain be maintained and the vaccines kept at correct temperature. Diverse types of storage facilities are used at different established centers.
Vaccines may be packaged in liquid or powder forms, the latter requiring reconstitution before use. Because these vaccines can be rendered impotent by direct exposure to heat or freezing, regular monitoring of storage temperature is imperative. Tools for achieving this include:

- Thermometers
- Vaccine Vial Monitor (VVM)
- Temperature logging chart
- Freeze watch
- Freeze tag
- Cold chain monitor card
- Continuous Temperature monitoring device
- Temperature data loggers

3.1.1 Open Multi Dose Vial Policy

Open multi-dose vial policy states that liquid vaccines opened for an immunization session, can be used within 4 weeks in subsequent sessions provided that all the following conditions are met:

- The expiry date is still within limits.
- The vaccines are stored under appropriate cold chain conditions.
- The VVM if attached has not reached discard point.
- The septum is not submerged in water
- Aseptic technique has been used

These apply to vaccine vials used in outreach and mass campaigns provided that standard handling procedures are followed.

Vaccine vials may be discarded immediately if:

- Sterile procedures have not been fully observed.
- Contamination of the opened vial is suspected.
- Evidence of contamination is change in appearance, visible and floating particles. Reconstituted freeze dried vaccines should be discarded at the end of 6 hours or at the end of immunization sessions or whichever comes first

3.2 Distribution:

Government shall ensure that vaccines reach the desired point of application with adequate logistics, which include cold chain facilities, through the PUSH-PULL system.
Government shall encourage Public Private Partnership (PPP) in vaccine distribution.

CHAPTER FOUR

4 STANDARDS AND SPECIFICATIONS

The equipment used for immunization services must conform to certain standards and specifications in line with WHO recommendations. This is important for vaccines, cold chain and logistics equipment to ensure global uniformity, quality assurance and safety.

41 Vaccines:

Government shall ensure that all vaccines meet the following standards:

1. Vaccine must be purchased from WHO prequalified manufacturers with the following parameters:
    - Batch/Lot number and expiry dates.
    - The dosage of the vial.
    - Product presentation - either liquid or powder form with the corresponding diluent.
    - Storage temperatures required for both long-term and short-term periods.
    - Country of manufacture.
    - VVM
    - Registration by the National Regulatory Authority (NAFDAC)

4.2 Cold Chain Equipment:

Government shall purchase WHO-approved standard cold chain equipment as contained in the Product Quality & Safety (PQS). Furthermore, all CFC equipment shall be phased out and replaced with CFC-free equipment that are environmentally friendly by 2015

The major cold chain equipment shall consist but not limited to the following:

- Cold rooms
- Cold vans
- Deep freezer
- Icepack freezer
- Ice line freezer/refrigerator
- Refrigerator
    - [Electric /gas/, solar]
- Cold boxes
-
- Vaccine carriers [giostyle, kick polio-rush]
- Icepacks of [0.6, 0.4, 0.3]
- Generators
- Thermometers
- Stabilizers.

4.3 Logistics Equipment

Government shall encourage and support the use of the following logistics equipment for immunization purposes as specified in the PQS:

- Motorcycles
- Bicycles
- Engine Boats/Canoes
- Life jackets
- Cold vans
- 4 wheel driven vehicles for reaching hard-to-reach areas.

4.4 Needles and Syringes

Government shall enforce the use of calibrated antigen dose specific auto-disable syringes and needles as contained in the National Policy on Injection safety. .

4.5 Waste Disposal

Government, and other stakeholders shall ensure that all contaminated injection materials, syringes and needles shall be immediately disposed of in leak- and puncture- proof containers which should subsequently be burnt in incinerators or burn and bury site

4.6 Training

Training on waste disposal shall form part of the training and continuing education of all immunization service providers.

4.7 Monitoring and Supervision

Monitoring and supervision should be a major component of immunization service delivery and appropriate personnel will be trained.

4.6 Basic Requirements of Cold Chain and Logistic Materials at LGA, Ward and Health Facility Levels

Minimum basic cold chain and logistic materials required for immunization shall be provided at all levels as follows:

S/N	ITEM	No.	REMARKS
	LGA Level		
	Motor cycles	3	Proper maintenance required
	Bicycles	10	Proper maintenance required
	Ice-line refrigerators	1	Provision of stabilizer paramount
	Deep freezers	1	Provision of stabilizer paramount
	Solar refrigerators	2	Proper maintenance required
	Vaccine carriers	20	Proper maintenance required
	Ice-packs	200	Proper maintenance required
	Thermometers	2/refrigrator	
	Megaphones	5	
2.	WARD Level		
	Motor cycle	1	Proper maintenance required
	Solar refrigerator	1	Proper maintenance required
	Vaccine carriers	10	Proper maintenance required
	Ice packs	100	Proper maintenance required
	Thermometers	2	
	Megaphones	2	
	Ledgers	2	
3.	**HEALTH FACILITY LEVEL**		
	Solar refrigerator	1	Proper maintenance required
	Cold box	1	Proper maintenance required
	Vaccine carriers	5	Proper maintenance required
	Ice packs	20	Proper maintenance required
	Thermometers	2	
	Mega phones	1	
	Ledgers	1	

CHAPTER FIVE

5 ADVERSE EVENTS FOLLOWING IMMUNIZATION

5.1 Introduction and Definition:

An Adverse Event Following Immunization (AEFI) is a medical incident that takes place within one month after an immunization and is believed to be caused by the immunization.

52 Policy Statement

1. All AEFIs from whatever cause, should be reported using standard reporting forms and investigated to increase public confidence and acceptance of immunization and help strengthen the immunization system.

2. Surveillance for AEFIs should therefore be established as an integral part of an efficient immunization system.

5.3 AEFI Surveillance

5.3.1 Adverse Events to be Included in AEFI Surveillance:

The following shall be included in AEFI surveillance:

1. All injection site abscesses
2. All cases of BCG lymphadenitis
3. All deaths that are thought by health workers, and/or the public, to be related to immunization, that occur within one month of an immunization
4. All cases requiring hospitalization that are thought by health workers and/orthe public, to be related to immunization, that occur within one month of an immunization
5. Other severe or unusual medical incidents that are thought by health workers and/or the public, to be related to immunization

Steps to be taken in AEFIs surveillance shall include:

- Detection and reporting
- Investigation
- Corrective and other action
- Evaluation

The following shall have responsibility for detection of AEFIs:

- Health workers providing immunization services
- Health workers providing clinical treatment of AEFIs in health centres, hospitals, or special treatment facilities

- Parents who report AEFIs affecting their children
- Researchers conducting clinical studies or field trials

5.3.2 Reporting AEFIs

- Hospitalizations and deaths, abscesses, lymphadenitis and other AEFIs shall be reported **immediately** to the LGA level and within 48hours to the State level for investigation.
- Copies of such report forms shall be sent to the National level
- All AEFI cases shall be compiled in routine monthly surveillance reports to the next supervisory level. Monthly totals or zero report, if no cases have occurred should be reported.

5.3.3 National Immunization Safety Committee:

A National Immunization Safety Committee shall be established to

- Review overall pattern of AEFI reports and investigation
- Provide causality assessment on investigations which have not reached conclusions
- Provide quality control on the system

5.3.4 The Composition of the National Immunization Safety Committee

The committee shall be composed of the following members:

1. Representative of the National drugs regulatory body – NAFDAC
2. National EPI Manager
3. A Paediatrician
4. An Infectious Disease Physician
5. Neurologist
6. Immunologist
7. Epidemiologist
8. Pharmacologist/Toxicologist
9. Logistician
10. Communication expert

5.3.5 Reporting Pathway and Responsibilities (see appendix)

The following shall be reporting pathway of AEFIs:

Peripheral Health worker - detect and report to LGA

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WARD/LGA level - investigates and completes AEFI report if criteria is met

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State level
- assess report
- investigates
- produce line-listing of reports received and investigated

↕

Zonal/National
- review information on state returns
- support state investigation

↕

National Immunization Safety Committee. - analysis and regular feedback down the line

The health worker who detects the AEFI or the supervisor who sees a pattern emerging among health facilities in the ward should initiate prompt investigation of all AEFIs. The ultimate goal is to find the cause and correct it. If the cause is identified to be programme error, remedial action can be taken promptly, and the public will be assured of the integrity of the immunization service. Even if the cause cannot be identified or the event was vaccine-induced, the fact that health workers investigated and the outcome properly communicated, can in itself increase public confidence in immunizations. In all cases, if parents or other members of the community are convinced that a medical event was caused by an immunization, they must be given the opportunity to discuss their concerns with health authorities.

5.3.6 Data collection

The following data should be collected for AEFI investigation:

- Data on each patient
  - demographic data, including a unique case number
  - history of present illness: symptoms, onset and duration, diagnosis, treatment, outcome,
  - history of past illnesses: reactions to previous doses, drug allergies, pre-existing neurological disorders, current medications
  - immunization history: vaccines, number of doses received, date and place of last immunization(s), site of injection
  - Laboratory results about blood, stool, or other samples, if appropriate.

- Data about the vaccine administered to the patient
  - lot number
  - expiry date
  - manufacturer
  - when and from where the vaccine was received
  - laboratory results about vaccine, if appropriate

- Programme-related data. These include:
  - Common practices in storing and handling of vaccines.
  - Giving immunizations, in the health facility in which the suspected immunization(s) were given.
  - Practices followed by health workers in:
    - Storing vaccines e.g. is DPT or TT frozen? Are expired vaccines used?
    - Handling vaccines during sessions, e.g. are DPT and TT properly shaken before use?
    - Handling vaccines after sessions, e.g. are all open vials thrown away after sessions?

  - Practices in reconstituting vaccines and giving immunizations:
    - Are the correct diluents used?
    - Are sterile diluents used?
    - Are the correct doses given?
    - Are vaccines injected in the right route and in the right place?

- Availability of needles and syringes:
  - Are one sterile needle and one sterile syringe used for each injection?

- Data on other people in the area:
  - Number of people who received immunizations with vaccine from the same lot or in the same immunization session, or both, and the number of those who fell ill and their symptoms. (Complete a separate AEFI case investigation form for each person)
  - Number of unimmunized people or people immunized with other lots (from the same or a different manufacturer) who fell ill with similar symptoms
  - Name of health worker who gave the immunization

All these should be recorded in the AEFI case investigation report.

5.3.7 Recording of AEFIs (see appendix for samples)

- AEFI Report Forms
- The AEFI Investigation Form: this provides a record of all available data on the patient
- AEFI Line Listing Form: list of persons suffering from AEFIs and investigated during the period
- The Event description report: this is a narrative describing and interpreting the event.

5.3.8 Taking Action

Treatment must be the first response to an AEFI.

Contents of AEFI KIT

AEFI Kits should be available in each Health Facility conducting Immunization services will include the following:

1. Adrenaline Injection
2. Hydrocortisone Injection
3. Analgesics
4. Normal Saline with Giving set
5. IV Canular and Tubing
6. 3x 5ml and 2x2ml Syringe and Needles,
7. Cotton wool
8. Tourniquet
9. Plaster
10. Antiseptic
11. AEFI reporting/investigation forms
12. Others as deemed appropriate

ANNEXURES

Annex 1: POLICY GUIDELINES ON LGA LEVEL IMMUNIZATION SERVICE DELIVERY

Preamble

Immunization service delivery as an integral part of child health services in every health facility (public/private) is aimed at reducing the burden of Vaccine Preventable Diseases (VPDs). This is expected to impact favourably on the status of child health in Nigeria. The LGA is the main repository of immunization service delivery through the wards and health facilities under its domain. This section presents the guidelines for implementing essential elements of the National Immunization Policy at the LGA, Ward and Health Facility Levels.

1. Ward Level:

1.1 There should be a Ward Development committee with membership drawn from key stakeholders

1.2 Every Ward to carry out a comprehensive yearly assessment, preceding the formulation of a Ward micro plan for PHC services

1.3 All Wards to conduct regular on -the -job training for health workers including mandatory IPC training.

1.4 All Wards must conduct mandatory bi-annual refresher courses of all health workers using approved immunization-training modules.

1.5 Every LGA should ensure self sufficiency in qualified health personnel who should be motivated to provide quality immunization services.

2. Service Delivery

2.1 Every health facility (public or private) must conduct immunization sessions at least once a week using fixed and/or outreaches. LGAs should conduct mobile services regularly.

2.2 Weekly immunization sessions should be used as a window for integration and delivery of child health services e.g. Malaria, growth monitoring and nutrition.

2.3 Mobilization of communities should take place immediately prior to scheduled immunization sessions.

2.4 Provide IEC materials for caregivers and the community to consistently create and increase in demand.

2.5 LGAs shall provide required logistics support for effective implementation of immunization services in all health facilities.

2.6 LGAs shall ensure availability of adequate potent vaccines at all health facilities (public and private)

2.7 Promote regular supportive supervision and conduct monthly review meetings.

2.8 Ensure community representation and participation in all review meetings

2.9 Ensure the use of AD syringes and the implementation of the safe injection and waste management practices.

2.10 To strengthen routine immunization and improve coverage, suitable incentives should be given to all children who are fully immunized.

3.0 Monitoring, Evaluation and Surveillance.

3.1 The LGA should establish monitoring and surveillance activities in every community. These activities include identifying and reporting occurrences and/or outbreaks of any VPDs to the nearest health facility, ward head, local health committee or PHC department.

3.2 Regular sensitization of the communities to be carried out to sustain the M&S established systems.

3.3 A feed back system should be established between the PHC department and the community as well as the health facilities. This implies that all actions taken on such reports be fed back to the communities.

3.4 All health facilities should collate monthly immunization service activities and submit through the Ward to the LGA authority.

3.5 Such monthly evaluation data should be reviewed and used for improved planning and implementation.

3.6 The PHC coordinator and LGA – Immunization officer (LIO) and their team members should randomly check immunization records at health facilities on regular basis.

4.0 Finance.

4.1 It is mandatory that every LGA has an adequate budgetary provision for delivery of regular immunization services

4.2 Community financial contribution should be encouraged and transparently managed.

4.3 Allocation of appropriate Imprest should be given to every health facility in each LGA for immunization service delivery

4.4 Yearly budgets must be made for PHC with immunization budgetary allocations clearly defined (Correct the numbering of this bullet!!!)

4.5 Timely release of budgetary allocation is an essential determinant of programme success.

4.6 Each LGA must establish a Child Health Co-ordination Committee (CHCC) to Coordinate in advisory capacity, management and financial matters.

5.0 LGA PHC MANAGEMENT COMMITTEE (LPMC)

This a Coordinating committee for child health services delivery, targeting immunization and other PHC services in an integrated manner. Members should include the followings:

1. The Chairman of LGA Chairman
2. Supervisory Councilor for Health
3. LGA Secretary (Head of Administration)
4. LGA PHC Coordinator (Secretary)
5. Representative of CH training institutions.
6. Principal School of Health Technology
7. Representative of Health- related occupational groups/associations.
8. The Chief (most senior) Community Health Officer in the LGA.
9. The Community development officer of the LGA.
10. The Medical Officer i/c of the secondary health facility
11. Chairman of ward development Committee
12. Representative of Traditional rulers /Ward Head.
13. Representative of International organizations with PHC programmes in the LGA.
14. Heads of other health-related departments in the LGA (education, Agriculture, works etc)
15. Representatives of NGOs.
16. Representative of Women/Youth groups.
17. Representative of Religious groups.

5.1 **TERMS OF REFERENCE OF THE LGA PHC Management Committee (As relates to Immunization)**:

1. Ensure implementation of LGA immunization policy
2. LGA monthly child health report to be presented regularly.
3. Reports evaluated by sub-committee and channeled for planning and implementation progress.
4. Responsible for resource mobilization.
5. Encourage health competition amongst Wards.
6. Reward best performing Wards using coverage and reduced disease occurrence as indicators
7. Ensure that LGA social mobilization committee function and impact on service delivery demand.
8. Forward quarterly reports to State (SMOH) and Zonal NPHCDA Offices.