BUILDING THE CAPACITY OF COMMUNITIES

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Peer learning programme: Adaptive leadership, IA2030 cohort 1 (2021)

KEY LEARNING POINT **Communities can play a critical role in improving immunization coverage, but they may need support to organize themselves and their activities.**

"The Federal Capital Territory of Nigeria (FCT) includes the capital city of Nigeria, Abuja, as well as rural areas, and covers an estimated population in 2022 of more than 5 million people. Many areas are very poor, particularly in the rural areas. In studies we carried out in the 2000s, we found that more than 90% of households were living on less than US$2 a day and I don't think the situation is very different today.

I have long been concerned about the delivery of immunization and other primary healthcare services to these populations. In 2013, the UN presented Federal Capital Territory with a second place award in the public service category for work I led on the *Mailafiya* initiative, which aimed to strengthen community engagement in primary health care planning and delivery. The idea behind this initiative was to use new digital technologies and intersectoral collaboration to strengthen primary healthcare and immunization services for the poorest communities.

A persistent need

Despite these successes, the people of FCT still do not have access to high-quality primary healthcare services. Immunization coverage is still not good enough (52% for Penta3 and 15% for measles-containing vaccine dose 2, MCV-2). Many communities in the FCT are therefore zero-dose or under-immunized.

There are many things we can do to improve coverage – we need to think creatively across all areas. For example, BCG vials typically contain ten doses. In clinics, vaccinators may be reluctant to open a new vial for one or two babies, but if they are not vaccinated then we may lose them forever. We can argue with the Government to change policy so that vaccinators do open vials, even if that means a little bit of wastage, and lobby the manufacturers to produce vials with fewer doses.

This case study is part of a series shining a light on the experiences of immunization and primary healthcare staff working at different levels of national immunization programmes in low- and middle-income countries. The people featured are all taking part in the IA2030 Movement peer learning programme organized by the Geneva Learning Foundation (TGLF).

This case study was developed to support the consultative engagement being undertaken by Immunization Agenda 2030 (IA2030) Working Groups. It was developed in collaboration with the Scholar featured.

We also have nomadic communities in the Territory. They move around pitching their tents, so we cannot be sure where they are. We have identified focal points in these communities who let us know where they are located. We then notify the nearest health facility, who go out to meet the travelling groups.

There are so many things we need to improve – the quality of microplan development and updating, the attitudes of healthcare staff, the lack of outreach. We need to work on all these if we are going to make a difference.

"There are so many things we need to improve."

People power 1 – the providers

A big problem we have is a lack of human resources – this was the focus of my TGLF project. I examined the staffing levels in health facilities in the Kuje Area Council, which covers an estimated population of about 400,000 in 2022, and found that many of them are understaffed.

Out of 41 facilities, only two could provide the minimum PHC service package. Five could provide facility-based services but no community-based PHC services and 21 could not provide adequate facility-based services or community-based PHC services. This means that over 80,000 children under 5 and 16,158 babies under 1 are not well served with limited available PHC/immunization services.

My proposed solution was to build up staffing levels in the facilities, making use of volunteers who would transition over time into full-time employees. I also hope to encourage corporate and individual sponsors to adopt PHC facilities to improve services and infrastructure, and also promote task-shifting to improve efficiency.

My short-term goal for my TGLF project is to ensure that 10 facilities employ volunteers – midwives and community health extension workers. My plan has been adopted by the FCT Primary Health Care Board and funding is available through Nigeria's Basic Health Care Provision Fund, which is supposed to receive a set proportion of Government income to invest in health services – 5% of funds are supposed to be used for midwives and community health extension workers and 5% for CHIPS agents, Community Health Influencers, Promoters and Services, who mainly work in the community on demand generation.

People power 2 – the communities

We will not be able to achieve success unless we can also get communities participating. Sometimes communities can take on very passive attitudes and expect Governments to sort out everything. My message to them is that they can do a lot themselves to keep themselves healthy and free of disease, including getting vaccinated. I say to them that prevention will keep them healthy so that they won't have to pay for treatment. Also, they can do a lot to make sure that health services meet their needs, by actively participating.

For many communities this is easier said than done. They may not be well organized and so cannot be expected to suddenly start taking part in planning or monitoring activities. It is therefore important that we build the capacity of communities to participate.

"It is important that we build the capacity of communities to participate."

For example, I have engaged with communities and helped them develop committees to liaise with health facilities. Existing community-based organizations can help build these bridges and support their activities. There are Government guidelines on how community health committees should be organized and operate. These include a requirement for a minimum number of women on each committee, so we may have

to work with committee organizers to ensure that they follow the representation guidelines.

We then help them develop plans for community health activities. Part of this relates to demand generation but it also provides a way to understand health needs in communities, and facilities can learn a lot about what services they need to provide and how they should be provided. We can also help them develop scorecards so that they are better able to keep a track of the number of pregnant women and babies and refusers, which will help ensure that the community is fully immunized and protects itself against vaccine-preventable diseases.

More generally, if communities are well organized, they can play a critical role in holding facilities and primary healthcare systems accountable. They can also advocate for the additional support needed to build the currently inadequate staffing levels.

If communities feel cared for and loved, I think they do begin to play more active roles in their own health protection and the whole thing is more sustainable.

The TGLF approach

I have found the TGLF model very helpful. I have followed it all the way through, from situational analysis and action planning. It has made me think about dividing my work into a series of steps and tracking activities week by week.

The information provided on responsive feedback was particularly helpful. However well thought out your plans are, only when you put them into action do you find out whether they work as well you hoped, and listening to the views of others can help you adapt them as you go along. This has made a big difference to how I go about things."

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