EMRO/SEARO MEETING ON THE PREVENTION OF NEONATAL TETANUS

EM-SEA.PREV.NNL.TTN/GR-2

Lahore, 22 - 25 February 1982

24 February 1982

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Report of Group 1

Question 1

The group suggested that in most developing countries at present, an incidence of neonatal tetanus of less than 1 case per 1000 live births would constitute a level where this disease might no longer be regarded as a major public health problem. This rate should refer not only to national incidence of this disease, but also to the incidence within each significant administrative sub division within each country.

The group also suggested, however, that a goal of Zero incidence might be adopted, recognizing that this had been achieved in most developed countries and recognizing that each individual case of neonatal tetanus demonstrated serious failings in the health care provided to the mother and child.

Question 2

1. Alternative Strategies

1.1 General Strategies

1.1.1 Obtain national committment to achieving the control at neonatal tetanus. This should be reflected in part by including tetanus among the notifiable disease and by including a specific category for neonatal tetanus. Countries should develop plans for the control of this disease which take into account the specific risk factors existing within that country and which specify a disease reduction target and date. National committment should extend beyond the Ministry of Health, as help from other Ministries will be needed, as for example, the help of the Ministry of Education in sensitizing teachers and pupils to this problem, and the Ministry of Information in promoting general information and education.

1.1.2. Seek the participation of the community in controlling this disease. Specific information concerning neonatal tetanus should be given to community leaders (including religious leaders) and their help should be sought in teaching birth attendants

and mothers to recognize cases of neonatal tetanus, to make them aware that it is a major killer of newborns and that it can be prevented by 1) immunizing the mothers prior to delivery, 2) assuring that the delivery is carried out and the cord cut under clean conditions, and 3) by assuring that no unclean dressings are placed on the cord while it is healing. In West Africa, it was noted that some communities had improved infant survival by providing shelters where mother and child could stay until the cord healed, under the supervision of a TBA.

Involvement of the community in the prevention of neonatal tetanus is most likely to be effective where this is promoted within the general approach of primary health care, and where strong links have already been established between the community, represented by a village health or development committee, and the health providers, represented by the voluntary and professional health workers.

1.1.3. Improve the training of birth attendants (nurses, midwives, TBA's) in the prevention of neonatal tetanus. They should be able to recognize the disease, and know it is a severe problem. They should promote the immunization of pregnant women and other women in the child bearing age group. TBA's should be trained to deliver the baby without contaminating the cord and to followup after delivery to assure that no unclean dressings are placed on the cord. They should be provided with simple disposable kits for severing dressing the cord. They should be trained to report births and deaths. All peripheral staff should be continuously motivated through supervision, periodic retraining and the use of periodic staff meetings where service statistics can be reviewed and problem discussed.

1.1.4. Improve the involvement of hospitals in the prevention of neonatal tetanus. Hospitals have a major role to play in providing immunization services within the hospital itself, in providing outreach primary health care services and in providing training, supervision and backup referral services for peripheral workers. Directors of the relevant hospital departments should be actively involved in the prevention of neonatal tetanus.

1.1.5. Involve other traditional healers in the prevention of neonatal tetanus as appropriate. An example would be barbers, who might be involved with circumcision, ear piercing or tattooing.

1.2. Immunization Strategies

1.2.1. Give first priority to assuring that every pregnant woman is adequately immunized. For previously unimmunized women, two doses of an adsorbed tetanus toxoid meeting WHO requirements should be administered. They should be spaced at least 4 weeks apart with the second dose at least 2 weeks before delivery. An additional dose should be given with the next pregnancy. Although additional doses may be given with succeeding pregnancies the mother and subsequent newborns will be protected for at least five years after the third dose, for at least 10 years after the fourth dose, and a fifth dose is likely to provide life time protection. For women previously immunized, immunization with 1 dose during the current pregnancy is recommended unless it is documented that at least a third dose of TT (or DPT or Td) has been given within the previous five years.

1.2.2. Next highest priority should be given to the immunization of married women in the child bearing age and third highest priority to unmarried women in this age. The fourth priority is immunization of school children, with consideration being given to offering immunization to both girls and boys if resources permit. Immunization of children in the first year of life with DPT already exists as a priority within the EPI.

1.2.3. The group recognized that it would be easiest to reach women who had ready access to health services, such as women residing in urban areas or attending school. All providers of health services should be sensitized to the need to immunize women in the priority groups, taking advantage of their visits for other purposes. The immunization should be offered rather than required, however, recognizing the need to encourage utilization of the medical services and recognizing also fears in some areas that the injection was for family planning rather than immunization. General public information and promotional campaigns to encourage the acceptance of TT immunization of women in the priority groups were also

1.2.4. Although services might be easiest to deliver in urban areas, the rural areas contain most of the population and probably have the highest incidence rates of neonatal tetanus. Although some rural populations could be covered using outreach services from hospitals and health centers, many rural areas could not at this time be covered in this way. Although mobile teams might have to be considered for reaching them, the difficulties of cost, availability of fuel and the maintenance of vehicles were recognized. Mobile teams should ideally be multipur-

providing a core of the primary health care services of highest relevance to the communities in question. Under certain circumstances, tetanus immunization of the entire population might be envisaged. In rural areas, every advantage should be taken of all workers who could support the programme, as, for example, malaria workers, lady health visitors, and sanitary inspectors. It was noted that the relative heat stability of tetanus toxoid might permit it to be used under circumstances where the cold chain was not yet sufficiently developed to permit the use of the other EPI vaccines, but also noted that even this vaccine could be quickly destroyed at high temperatures (above 55°C).

Although recognizing that many categories of health workers including the TBA, could administer TT injections if they were carefully enough trained and supervisied; the group expressed its general caution concerning the use of traditional practitioners not under the direct employ and supervision of the government to provide injection.

In areas where it is not yet feasible to provide effective coverage with TT, main reliance will have to be placed on sensitization of community leaders to the problem, and prevention through improved delivery and postnatal care practices.

Although it made several general suggestions concerning rural areas, the group felt that it was not yet possible to define an ideal approch. The group hoped that such approaches could be developed in each country, based on further analysis which would identify the specific women who were at the highest risk of having a child die of neonatal tetanus. Outreach strategies might then be evolved which could increase their coverage more quickly than for all women in the country.

3. Resources:

Much can be accomplished using existing resources, but additional resources will be needed to achieve satisfactory control of this disease. Some of these are needed for the EPI and for Primary Health Care as a whole. As evidence by the coverage rates now being achieved in children, vaccines were already being made accessible to significant proportion of the population without increased resources, and immunization rates among pregnant women and women of child bearing age should be able to be brought close to those for children. But, in addition to the additional resources needed to increase the general coverage of immunization services, some special additional investments for maternal tetanus prevention are also

needed. These include the development of special health education and promotional materials concerning this diseas, investments in additional epidemiological studies to better define high risk women, and evaluations of neonatal tetanus prevention initiatives so the most successful and cost-effective approaches can be idenfified and promoted.

A number of different groups could be approached to help in providing such additional resources. These included various women's groups, the UNFPA and IAMANEH.

4. Constraints/Obstacles:

Many constraints and obstacles have already been mentioned. A major problem at present is that neither the medical professional staff nor the public at large is aware of the extent of the problem of neonatal tetanus nor is committed to its control. A big job of information/education remains to be done, and government will need to identify specific resources to do it. This will be best done in the context of efforts to sensitize the public to other related issues, such as the importance of the immunization of children and the importance of prenatal care of mothers.

In some area, satisfactory control of neonatal tetanus will have to await the development of an adequate system of primary health care. and promotion of the approach of primary health care in general should accompany promotion of the prevention of neonatal tetanus. The control of neonatal tetanus and of other disease included within the EPI can and should be used as an opening wedge in developing primary health care.

5. Target date:

Every effort should be made to achieve the prevention of neonatal tetanus by 1990, the target date for the EPI as a whole. Yet a firm date can only be expected to be set realistically once countries have had more experience in implementing their control programmes and a followup meeting in 2-3 years time to evaluate progress would be most useful.

Question 3

The group concluded that the identification of immunized women using a card retained by them, was highly desirable as a tool of programme management and evaluation, as an aide for health education of the mother and as a safety measure to assure women were not unnecessarily immunized.

Where a general health card was in the possession of the women immunized, this should serve as the record. Otherwise a special card could be issued. Immunization cards should be made widely available for use by private Physicians as well as for use in the public sector.

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