EMR/SEAR MEETING ON THE PREVENTION OF NEONATAL TETANUS

EM-SEA/MTG.PREV.NNL.TTN./GR.3

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Chairman : Dr. A.A. Khan
Rapporteur: Dr. P.M. Shah

Report of Group 3

1. LEVELS AND TARGETS

1.1 The group is of the view that to achieve control of neonatal tetanus, there should be no cases in urban areas and in other areas it should be less than 1 per 10 000 live births.

1.2 Target oriented planning should be considered in areas where neonatal tetanus is a problem.

The targets suggested should be a reduction to 50% of present levels by 1985 and to 25% of present level by 1990.

1.3 All countries where there is a neonatal tetanus problem (as evidenced by the presence of cases in hospitals) should conduct a baseline on the lines recommended, in 1982 if they have not done so within the last three years.

In all countries this survey should be repeated in 1986 and in 1991.

1.4 Neonatal tetanus should be made a notifiable disease all countries.

2. STRATEGIES

2.1 Prevention by Immunization

The following should be the target groups:

2.1.1 Infants, with at least 3 doses of DPT.

2.1.2 School entrance: D.T. x 1 if immunized earlier
x 2 if not immunized earlier.

2.1.3 Primary school last class (about 10 years of age)
D.T x 1 (or T.T.)

2.1.4 Secondary school last class T.T. x 1

2.1.5 Children who do not attend school: Every institutionalized point of contact should be used according to local circumstances, e.g. rural development centres, primary health care units, hospitals, and similar opportunities.

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2.1.6 In countries where it is feasible, evidence of tetanus immunization could be made a requirement of necessary marriage certificate.

2.1.7 Pregnant women plus any female who has not been previously immunized, and who bring a child for immunization, or at any other appropriate point of contact with the health services.

2.1.8 For all people, male or female, it should be re-emphasized that care of wounds or injuries should include not only disinfection but the administration of tetanus toxoid in all cases where there is reason to believe the person has been previously immunized. Antitoxin should be reserved only for those who were not immunized, and even with the tetanus toxoid 2 doses should be given. (Combination of passive and active immunization).

2.1.9 Once incidence is down to 5-10 per 1000 live births then appropriate surveillance (sectoral) centres should be identified who will map the distribution of the origin of the cases; so that by means of outreach or house-to-house programmes efforts can be concentrated in these localities.

2.1.10 The role of mass campaigns
Although we do not recommend mass campaigns as a generally applicable strategy, we acknowledge that there may be certain centres where this cannot rationally be implemented, e.g. where there is already mass campaigns such as for yellow fever vaccination in West Africa; or where the government is convinced that it can achieve very high coverage and maintain the level afterwards and that this will be cost effective.

2.2 Improved Maternity Care

It is recognized that improved maternity care has a vital role to play in reduction of neonatal tetanus as well as much more than that in reduction of neonatal mortality and morbidity and

maternal morbidity and mortality.

All countries with high neonatal tetanus rates are also countries where a large proportion of women are delivered by untrained unsupervised TBAs.

All governments urged to register all TBAs, train them, with emphasis on referral of high risk cases, safe delivery, and adequate hygiene including care of the cord; and attach them to health teams. In brief the sequence should be

(1) Register TBAs.
(2) Train them at the most ? point feasible.
(3) Equip and supply them appropriately.
(4) Link or attach them to the health team.
(5) Supervise and support them.
(6) Give them refresher training.
(7) Renew registrate periodically.

Supervision of governments should strengthen the MCH or basic health service network of centres and trained staff such that every ten TBAs have supportive supervision from a nurse or midwife.

Similar supervision should be provided also for assistant or village midwives or TBAs who are already trained, and not only to newly-trained TBAs.

Third level supervision. The nurse midwives themselves require and desire supportive supervision from the central or provincial responsible officer. This should be organized in a regular and systematic manner, with a standard fact report on every visit made.

2.3 Health Education supportive of both the above strategies

The target of the education is essentially the mother. However, she can be reached both directly by health staff at centres and indirectly some of the important possible agents of this could be:

(1) The husband. (2) The TBA. (3) School children.
(4) Religious and other local leaders or volunteers.
(5) The mass media.

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2.4 The Environment

It is acknowledged that the keeping of cattle and horses in or near the house is an essential part of the rural economy in many countries of our region, and that change will come only gradually. However, there are a few situations in towns of our region where it is possible to forbid the stabling of horses or ~~cars~~ cows overnight within the municipal limits.

2.5 Resources required

It seemed to the group that most governments could absorb the relatively small additional costs within the present health budgets, or meet them by appropriate re-allocation of expenditures.

3. IDENTIFICATION OF IMMUNIZED

The group felt that this was necessary, not from the point of view of hyper-immunization but for the purposes of coverage evaluation.

Possible means included:

Cards

Optimal : Family-health cards
Home-based mothers' card

Other ; EPI card
Identity card

Tattooing was felt to be impracticable in most countries, and in any case had some hazards in itself.

Plastic discs may well be possible in many countries however.