REPORT OF THE CHANGE AGENTS IMMUNIZATION STUDY TOUR TO TANZANIA 25TH AUGUST-4TH SEPTEMBER 2005

Pre study tour Workshop held at the Lagos Airport Hotel, Ikeja, 26th September 2005

Facilitators: Dr Ibrahim Oloriegbe, Dr Mechthilde Wagner, Dr Ben Anyene.

Workshop started promptly at 9.am with Dr Wagner's welcome speech which included a brief presentation of the EU-PRIME Project organization structure workings and objectives. She also anchored the introduction of participants and stated that the objectives of the EU-PRIME Project included the following:

- To eradicate the disease burden of vaccine preventable diseases
- To improve routine immunization coverage to 80% by ensuring that vaccines are available at all levels
- Eliminate Maternal and Neonatal Tetanus
- Training of personnel on routine immunization
- Provision of a new and workable plan for routine immunization

She identified the challenges of the project as:

- Primary Health Care facilities not always working
- Cold Chain equipment not always available
- Infrequent immunization days
- Inadequately trained personnel

The opportunities that were identified include;

- Technical Assistance
- Purchase of Equipments
- Funding of Recurrent costs
- Employment of local specialists in the six states
- Training leadership of the ICC
- Change Agent Programme study tours to other countries with good immunization services

The CAP components of the EU-PRIME Project are:

- To reform the immunization services at National level and the 6 selected EU-PRIME focal states which are: Abia, Cross-River, Gombe, Kebbi, Osun and Plateau states.
- To advocate immunization reforms for improved health outcomes and National development
- To foster collaboration and resource mobilization for immunization reforms
- To monitor and critically appraise the immunization services delivery performance to inform policy development towards improved immunization services delivery.

Dr. Ibrahim Oloriegbe said the Change Agent Programme was developed as a response to the unsatisfactory performance of the Nigeria Health system as adjudge by WHO 2000 World Health

Report and Consultants assessment which placed Nigeria in the 187th position out of 191 countries. He stated that the basic tenet of CAP is that sustainable change has to come from within and be institutionalized. However the change will not happen without CATALYSTS. The catalysts are the Change Agents. He said that CAP is taking the faith of Nigerians into Nigeria's hands and that the movement has grown from the initial 25 Change Agents to 350 Nationwide with the help of the initial 70 selected CAs that were exposed to HSR, ISR and HIV/AIDS.

The purpose of the Change Agent Programme is to foster broad Health Sector Reform specifically reform in the Health Services such as provision of Immunization Services and HIV/AIDS prevention services.

He stated the objectives of the PreTour workshop objectives to include the following:

- To enable participants understand the concept of Change Agent Programme (CAP) and attributes of Health Change Agents
- To enable participants understand how to assess an immunization service
- A consolidation of participants knowledge and experience of Nigeria Immunization System and recognize the factors responsible for the current state of immunization services in Nigeria
- To enable participants understand objectives of the Tour to Tanzania
- Assist participants to select individual objectives and areas that will be developed into proposals for implementation after the Tour
- Brief and discuss tour itinerary with the participants
- Foster greater interaction among the group of Change Agents

.
The ground rules which will guide the workshop and the study tour were set and they are:

- No phones ringing and no calls taking during sessions
- All participants are expected to contribute
- Permission must always be sought from the facilitator before speaking
- Permission must be taking before going out
- One person should speak at a time
- No side comments
- No Loitering
- All opinions are valid and must be respected

The attributes of a Change Agent are stated to be as follows:

- Being capable to see how things can be done differently (Visionary)
- Have a good understating of Nigeria Health System/ Sector particularly immunization
- Ability to critically appraise other Health Systems with an open mind
- Ability to take advantage of opportunities and be innovative
- Good communication skills
- Have drive and commitment
- Good understanding of change process and how it can be effectively pursued in Nigeria

The factors to be considered in assessing a country's immunization system include

- Political structure of a country
- Economy
- Demography
- Geo-political structure
- Health policy
- Immunization policy
- Structure of Health System
- Immunization data generation, collection and analysis
- Sources and distribution of Health Sector Funding
- Vaccine Purchase
- Storage and distribution
- Immunization Service delivery strategies
- Human Resources in Immnunization

Dr Ben Anyene anchored the Assessment/Analysis of current situation of the Nigerian Immunization System. This was identified as being weak and under-functional. The overall objective of CAP is to develop strategies to strengthen it.
The weaknesses in the immunization system in the country were identified to be as a result of:

- Inadequate funding
- Lack of political will
- Unreliable data
- Inadequate vaccine
- Poverty
- Lack of transport for movement of vaccine
- Lack of coordination between levels
- Lack of commitment
- Lack of cold chain equipment

Participants were grouped into two and were made to identify weaknesses at various levels (Federal, State, LGA and Community) and suggest practical solutions on the way forward for immunization services in Nigeria

Presentations of the groups are as follows:

Presentations

S/N	"WHO" RESPONSIBILITY	WEAKNESS/PROBLEM	SOLUTION/WAY FORWARD

1	**FEDERAL**	• Lack of political commitment	• High level of advocacy and sensitization should be done to educate and sensitize policy makers on the need to be committed to Health issues
		• Poor budgeting system	• Effective and workable or realistic budgeting system should be put in place.
		• Bureaucratic bottlenecks • Too much emphasis on PEI by Federal Government and International Organizations	• Health related matters should be treated with dispatch. • More emphasis and resources should be geared towards strengthening routine immunization system in the country.
2	**STATE**	• .Inadequate Manpower supply (Quality and Quantity)	• More personnel should be employed and trained to be able deliver quality routine immunization service.
		• Inadequate funding of the health sector at the state level.	• Adequate provision should be made to accommodate health matters at this level.
		• Frequent transfer of health staff.	• Staff should be allowed to work in familiar environment to be able to continue what they have begun.
		• Lack of personnel motivation.	• Staff should be adequately motivated to productive result.
		• Lack of infrastructure.	• Adequate infrastructure should be provided for effective operation.
3	**LOCAL GOVERNMENT**	• Ignorance of policy makers on health matters.	• Local government policy makers should be adequately sensitized about health issues.
		• Rationalization of Local government grants by the state government.	• State government should increase grants released to LGA.
		• Emphasis on political structure/quota system.	• Political structure/quota system should be de-emphasized.
		• Poor quality and inadequate manpower.	• Increase and train personnel.

		• Indiscriminate transfer of health staff. • Lack of personnel motivation. • Lack of team work spirit.	• Staff should not be moved at random to avoid distorting the system. • Staff should be adequately motivated to put in their best in the system. • Health staff should be taught the benefit of learning to work as team to produce the better result.
4	**COMMUNITY/INDIVIDUAL**	• Poor Knowledge.	• Health education.
		• Inability to ask for rights.	• Mobilization and sensitization.
		• Poverty.	• Community/Individuals should be economically empowered to be able to appreciate health services.
		• Accessibility.	• Health services and facilities should be made available to the community and individuals.

The Principles of an effective immunization system were discussed and these are

- Efficiency
- Effectiveness
- Availability
- Accessibility
- Cost Effectiveness
- Sustainability
- Resource oriented
- Acceptability
- Effective communication

The contents if an effective immunization system are stated to be the "whats" that make an immunization system effective and they include

- Stewardship Role of Government
- Strengthening the Immunization System
- Reduction of Vaccine preventable diseases especially those with high mortality rates
- Access to quality health / immunization services
- Community awareness and involvement
- Resource availability especially the 3 Ms-Men, Material, Money

- Promoting partnership , coordination and collaboration
- Effective communication strategy
- Immunization Monitoring and Evaluation supervision

The Characteristics of an effective immunization services are as follows

- Ability to work as a progressive team
- Having clear and shared understanding of vision, mission and objective
- Having working understanding of roles and responsibilities of all parties(published)
- Put together a coherent and unambiguous plan of action that is implementable and sustainable
- Bottom-up approach in conceptualization, design and monitoring, evaluation and supplementation.

Project proposals of each participant to be undertaken post tour were made and these are

S/N	Participant Name	Project Proposal to be undertaken post Tanzania tour
1	Dr Obiora Ezebilo	Designing a structure for producing maintenance officers for cold chain
2	Dr Ajao	Vaccine Distribution-Specifically ensuring availability at Health Facilities- Government Partnership and community ownership
3	Miss Imoke Bassey	1. Data Management, capacity building of health Immunization providers 2. Immunization services delivery in hard to reach areas
4	Mr Yakubu Daarinka	Community mobilization and sensitization in Gombe State
5	Alh Rabiu Koko	Community ownership of immunization
6	Miss Princess Okonkwo	Data Management training for LGA/HF in 6 EU-PRIME Focal states
7	Mrs Martha Kibadau	Strengthening social mobilization at the community level
8	Dr Taiwo Avbayeru	Routine Immunization in women of reproductive age in Nigeria
9	Mr Patrick Chukwuma	Evaluation of BASICS CAPA system after 1 year-What Next?
10	Mr Anyang I	Sustainability of programmes-post EU-PRIME Project
11	Dr W Chidama	Capacity building for immunization waste disposal in EU-PRIME 6 focal states

Dr Olorigbe enjoined participants to seek at all times to know more about immunization both countrywide and worldwide and that CAs should concentrate more on helpful processes and not contents

On a final note, the participants thanked all and pledged their cooperation and commitment

The tour itinerary was discussed and the workshop ended with prayers just as it had started with same.

FIELD VISITS – 29th August- 2nd September 2005

The Change Agents in company of key officials of Tanzania Public Health Association conducted field visits to:

- **Ministry of Health**
- **City Ministry of Health**
- **Municipal Ministry of Health Temeke**
- **EPI Programme**
- **Reproductive and Child Health Unit Muhimbili Hospital**
- **Municipal clinic Temeke**
- **Private clinic, Temeke**
- **Medical Stores Department**
- **UNICEF**
- **WHO**
- **European Commission**
- **Morogoro Regional Administration**
- **Regional Health Management team, Municipal Health Management team, District Health Management team(Morogoro Region)**
- **Morogoro Municipal Clinic**
- **Rural Health center and dispensary**

MINISTRY OF HEALTH, DAR-ES-SALAAM, TANZANIA

At the Ministry of Health the main focus was a courtesy call to Ministry of Health top ranking policy makers to understand the following:

- Structure of the Tanzania Ministry of Health
- Organization of the EPI system within the ministry and the role of the ministry in the EPI programme
- Integration of the EPI into PHC system
- Coordination of various levels for effective EPI implementation
- Challenges faced within the programme

Presenters:

Dr ----------	(Ag Permanent Secretary MOH)
Dr R O Swai	(Ag Chief Medical Officer MOH)
Dr E P Mungongo	(Acting Director Hospital Services)
Nsachris Mwamwaja	(Communication Officer)
Joseph Mgaya	(DG, Medical Stores Department)
C Ugullum	(Director Food and Drugs Administration)
Dr Mutahyabaruag	(Director, Human Resources)
David Manyaba	(Deputy EPI Programme Manager)
Nuru Abdullahi	(Chief Accountant)

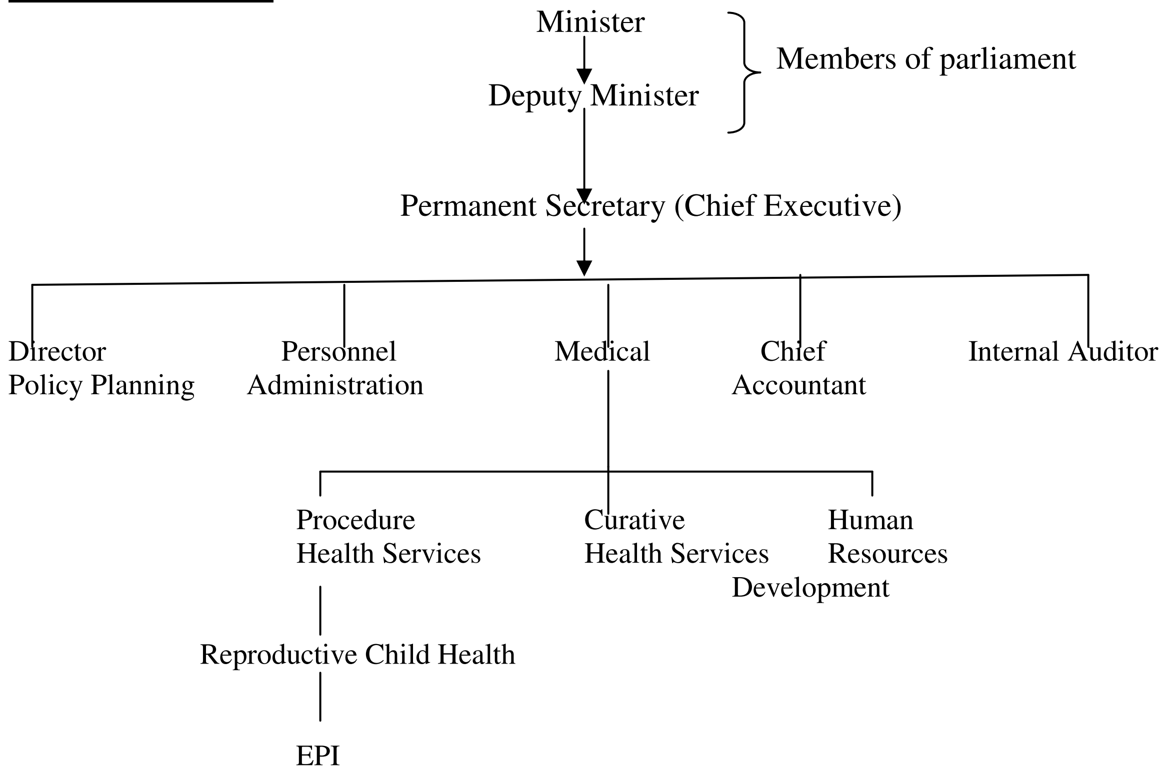
Barthlomayo Ngaeje (Director, Preventive Services)

The acting chief medical officer gave a brief overview of the responsibilities of the central level which he said included Policy formulations, Planning, Support supervision for districts not performing well or not up to acceptable standards, personnel training especially in in data management, Procurement of vaccine through UNICEF or some WHO accredited agents to ensure uniformity and quality, Monitoring and Supervision, Waste management

The EPI programme in Tanzania which was launched in 1975 with sole aim of decreasing the burden of vaccine preventable diseases coverage as at 1985 was 50%, and now over 80% for all antigens. In 1996, EPI was integrated into the HSR and the integration did not negatively affect the EPI delivery in the country. With improved surveillance it was discovered that there was decrease cases and fatality for measles. Case fatality for measles decreased to less than 1%. 119 districts have eliminated neonatal and maternal tetanus as at now. The country became polio free since 2000. There has not been a case of Petusis since early 80s.

The EPI service itself is under the Preventive Health Services Department and with reproductive & child health services programme.
The 3 Tiers of government responsible for EPI programme are the central, regional and district.

Structure of MOH



Lessons learnt:

- With good planning, financing responsibility can be transferred from donor to government even in poor resourced countries
- Effective implementation of the EPI programme may be more practicable if it is decentralized

- Clear demarcation of the roles and responsibilities of the different tiers of government as regards EPI implementation and strictly maintaining that is sin-quo- non to the success of the EPI programme.
- Private health facilities could be convinced to offer immunization services free
- Support supervision is used to encourage and motivate under-performing districts.

CITY COUNCIL OF DAR ES SALAM

Presenters:

Dr Mtasiwa	(Regional Medical Officer/Head of Dept CMOH)
Chiku Gallawa	(Coordinator, Curative and Research)
Sylivia Lawi	(Coordinator, Reproductive and Child Health)
Winifrida Kamugisha	(Coordinator, Preventive Health Services)

The main focus of the visit was to study how EPI is implemented especially how the various levels relate to ensure success and to assess the various structures on ground.

The following was noted.

- .It is an urban Region.
- There are three Districts.
- Population under-estimation was affected by the rural-urban drift, which affected staffing, and equipment supply thereby resulting in low coverage of the area.

The health reform, which started in 1959, boosted in the following:

- personnel
- power of purchase
- community involvement
- increased number of health facilities became involved in immunization
- Vaccine are centrally purchased at the national level distributed to the Regional levels and finally to the districts.
- This function is performed by the Medical Stores Department (MSD)
- About 40-50% of the funds come from Basket funding which is mainly Partners fund. The partners still fund other activities in addition to their contribution into the Basket funding. The total contribution from the Partners is as high as 80%
- Current RI coverage are as follows:

BCG -	98%
OPV0 -	87.5%
OPV3 -	92%
DPT3 -	92.8%
Measles-	92.8%
Vit. A -	98.8%
T.T-	91.7%

- Total Health Facilities is about 480 with Private Health facilities of about 93

Lessons Learnt:

- There is effective team approach
- Accurate census is very important
- A times some degree of liberalization of the system may be necessary
- The health authority were in good grip of the Health facilities especially the Private Sector

MUNICIPAL COUNCIL OF HEALTH

Temeke Municipal Council Headquarters
Presenters:

Dr. Jerome Kamwela (Municipal Medical Officer of Health)	
Dr. Ruta	
Daniel Kayanda	(Heallth Secretary)
Martha Mwasi	(Social Welfare Coordinator)
Mary Mgaya	(Mental Health Coordinator)
Godfrey Mwangairo	(Supplies Department coordinator)
Lawrence Chipatta	(HMIS Coordinator)
Dr Mathias Lyaruu	(MACC, Temeke)
Gasper Rutandurua	(Health Programmes Coordinator)
P P Akaro	(District Cold chain Officer)

The presenter gave a brief history of the council as being one of the three municipal councils in Dare-es-salam region. It has an area 7656sq.km and consist of different ethnic groups some of whom migrated from all parts of Tanzania. Although the municipal has good roads, there are still some roads which are not accessible during the raining season. The council has 3 hospitals, 24 dispensaries, 69 RCH, 43 private health institutions, 112 out-reach and one mobile clinic.
Immunization services are provided between Mondays and Fridays. In the year 2005 so far 848,714 persons have been immunized, 162,745 for children under 5 years and 152,769 women of child bearing age. Some health facilities in the area are also equipped for the screening of HIV.

Challenges:

- Inadequate staff
- Resistance of women of childbearing age against TT
- Lack of access roads during raining seasons

Lessons learnt:

- The council has a very good plan in health care programme which is also well implemented.
- There is a good system of vaccine supply and on regular basis
- There is participation of private practitioners in the health service delivery and immunization as well as effective community sensitization and mobilization in collaboration with Community Resource Persons (CORPS)
- The councils coverage for routine immunization is high
- Constraints are in-adequate staffing and some resistance from women of child bearing age
- The council has put in place effective supervision mechanism, efficient data collection, collation and custody system.

EXPANDED PROGRAMME ON IMMUNIZATION (EPI) MABIBO
Presenters

Dr David Manyanba	(Deputy Manager, EPI)
Sigsbert Chamlungu	(Data Manager)
D Mujum	(Asst Data Manager)
Jean V M Bomani	(Administrator)
K G Kagaruki	(National cold chain/ logistics officer)

Margaret Fimbo (National Training Officer)

Main focus was the Structure and operations of EPI in Tanzania.

EPI is a unit under the RCH structure (a section under the department of Preventive Health Services). EPI has the privilege of reporting directly to the director Preventive Health services to ease bureaucracy bottlenecks so that services will be dispensed promptly and effectively at any given time. The unit however briefs the RCH coordinator on its activities.

RCH through the EPI structures is responsible for immunization service delivery at HF_S and service delivery. Government HFs runs throughout the week (Mondays to Fridays) whiles the private HF render services twice weekly in most cases. There is a clear evidence of community participation and private public partnership. The capacity of the staff rendering immunizations is well built and there is integrated approach to service delivery.

Vaccine and other logistics procurement are centralized and forecast is made by the EPI using the demographic data (Target population) through bottom up approach. Vaccines are procured by the MSD through open tender using the Government and development partner's funds. Vaccines and devise distribution are made by the MSD to the Zonal offices. The zones in turn distribute to the regions where they are picked by the district to the HF_S for final utilization.

There is a human resource policy with clear guidelines that spelt out that responsibility. The staffing method is both qualitative and quantitative. This policy created training programme for locally sourced personnel these include Assistant Clinical Officers, clinical Officers and Assistant Medical Officers emerge.

Data is primarily generated at HFs level collected and collated by the Districts who in turn make them available to the regions and then the central level for final analysis.

There is support supervision, monitoring and evaluation being undertaken by the unit and which is budgeted for, in the National Health Budget.

The MOH co-ordinates the various stakeholders (Government and development partners)

The MOH also has good collaboration with the private health care providers and the traditional healers.

Lessons learnt:

- Immunization is a public good
- Strong commitment at all levels
- Annual work plan which is implemented
- Annual review meeting
- Effective vaccine distribution system
- Autonomy of the EPI
- Stable power supply
- Well trained staff
- Community participation

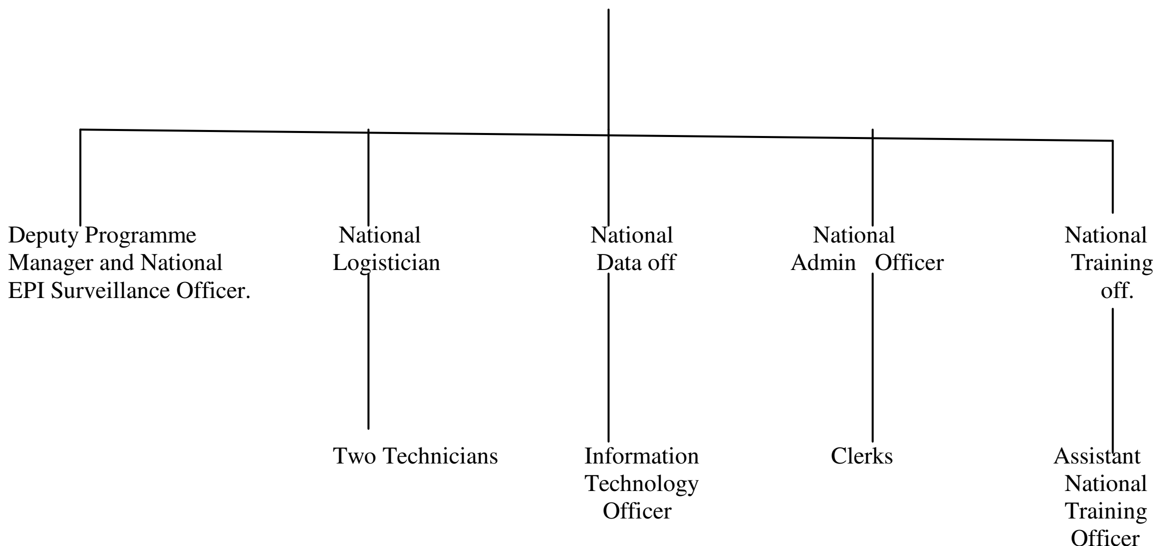
- Integrated service delivery system

Structure of EPI

- EPI manager
- Surveillance Officer
- National Logistician
- National Data Officer
- Administrative Officer
- Training Officer

EPI STRUCTURE

National EPI Programme Manager
Coordinates the EPI programme at all levels with major emphasis on the central level government



- Total: No of staff at the National Level = 16
- There are 7 Zonal offices with a Zonal coordinator (who coordinates other RCH activities also) and a training officer
- There are also development partner staff at the Zonal level

MUHIMBILI NATIONAL HOSPITAL:

Reproductive and Child Health Unit (RCHU)

The main focus of the visit was to know the role of the unit in immunization services, organizational structure and funding.

Presenter: Head Reproductive and Child Health Unit.

The Child Health Unit is under the directorate of (Preventive Health Services (P.H.S.), R. C. H. U has the following units:-

- Reproductive
- E.P.I
- T.B.L
- O.C.H.N
- Environmental Unit
- Safe motherhood
- Epidemiological Unit
- Food and Nutrition
- HIV AIDS
- Health Education
- Malaria Control

The basic functions of R.C.H are co-coordinating the activities of all units under the department. The unit performs the following functions

- Policy formulations
- Coordination
- Guidelines and standardization of capacity development for service providers
- Monitoring, evaluation and supervision at the regional and district levels
- Collates reports from all units.

Though the E.P.I is hierarchically under the RCHU, the head EPI unit can report directly to the Director, Preventive Health MOH while the Head of R.C.H. would be informed.

LESSONS LEARNT

- There is collaboration and co-coordination between the units
- There is continuous in-service training of all cadres of health personnel especially those in the immunization services unit

MUNICIPAL CLINIC TEMEKE (Nbagala Round Table Maternity Home)

Presenter:

Dr. Theresa Idifu (Assistant Medical Officer I/C)

Main Focus of the discussion:

- To see how they perform their services.
- To also observe they way they interact with their patient
- How immunization is conducted.

The home only attends to women and children, women during anti natal and delivery. Approximately the home delivers up to 10 patients in a day. Also offer postnatal services

Services

- Admits children for immunization and growth monitoring services.
- Get their vaccines supply from Temella Hospital. There is a research institute adjacent to the home. Immunization is done every day of the week.

LESSON LEARNT:

- The women are well mobilized and sensitive on immunization and growth monitoring, evidence of community involvement.
- It was proved that no matter the pressure of work, one should be dedicated and disciplined.
- The importance of record keeping cannot be over emphasized. This was done and displayed at the Maternity Home.
- The need for continued education. This helps to broaden knowledge and for effective and efficient performance.
- In counseling clients, special attention should always be taken to consider their economic, cultural and religion etc. background Special attention should be given to HIV/AIDS matters.
- Patient should not be kept for at least more than two hours in a health center, i.e. that prompt attention is given to patients/clients as they visit the center.

PRIVATE FACILITY VISIT

Main Focus of the visit was the role of Private Practitioners for profit in RI service provision

- Private practice can deliver free effective and efficient RI
- MCH unit for RI available
- Facility registered by District for RI services
- Nursing attendant: Primary Six and 3 years, post qualification in charge of MCH
- Training and Refresher courses offered free by EPI (Govt.)
- Logistics supplied free by EPI through the District
- Vaccines collected free – Pull System from a Public facility
- Immunization twice weekly for catchments (target) population
- RI given free twice weekly
- Data collection regular and efficient
- Patients satisfied with services: Good & efficient; Near to resident.

LESSON LEARNT

- Regular and continuous free training of personal boost the confidence of providers
- RI can be delivered effectively and efficiently through PPP
- Cost sharing functional and beneficial to both
- PT patronize private provider for RI – they have confidence in their selves
- Example of a mutually beneficial PPP in action
- Quality Assurance maintained by strict adherence to guidelines, M & E

MEDICAL STORES DEPARTMENT (MSD)

Presenters:	Beatus Nsoma	(Head, Vertical Progrmmes)
	Jamal R Ally	(Manager, Customer Services)
	Christine Lissu	(Manager, Sales)

MSD was established in 1993. MSD is an autonomous body. It took over activitities of the central store. MSD has 6 zones for operation. EPI and other health programme normally make request for items while MSD do the procurement and distribution to the zones and then to the regions. Procurement by MSD is based on open tender. MSD charge the government for services provided based on volume of procurement with a MOU signed by the government and MSD. In some cases charges are based on of doses supplied and in some cases based on distance (Mileage Calculation)
The salaries of staff are determined by the board. MSD staffs are paid higher than staff of the main ministry.
The body has a board of trustees headed by the Chairman who is appointed by the President. Other members of the board include;

- Representative of Ministry of Health
- Representative of Ministry of Finance
- Representative of Hospital Services
- Representative of customers
- Representative of Private outlets
- Neutral observers
- Representative of Partner Agencies

A Director General heads MSD, which is currently being paid by DANIDA.The DG, is normally replaced by open bidding by other directors. It is made up of 5 Directorates each of them is headed by Directors. These directorates are:

- Directorate of procurement
- Directorate of finance/audit
- Directorate of logistics
- Directorate of sales/consumer services
- Directorate of information technology

MSD operations is limited only to public/government health facilities with some specific private hospitals like mission hospitals

Lessons learnt:
- MSD is a transparent organization
- A lot of commitment is seen on the part of the workers
- There is clear cut schedule of duties
- Vaccines are distributed down to the regions
- Vaccines are bundled
- The organization is being audited by government

UNICEF

Presenter: Dr Samson Agbo (Country Rep)

Focus of Discussion**:**
The main objectives of the visit to Tanzania and UNICEF as follows

- To see how immunization is being implemented in Tanzania in view of the success recorded in terms of coverage, efficiency and effectiveness.
- To see the interplay between EPI strategies and the health Sector reform.
- To see the role UNICEF is playing in the EPI success story in Tanzania including the basket fund.
- To determine the sustainability of the EPI programme in Tanzania and
- To see how the downward trend of the National programme on immunization (NPI) in Nigeria could be halted and reversed within the shortest time possible'

The UNICEF Health Advisor who incidentally is also a Nigerian said he was very pleased to welcome the team to Tanzania. He gave an overview of the political structure of Tanzania, the roles and responsibilities of the various tiers of government and how the immediate past socialist experience of Tanzania and the decentralization of the political and health system have contributed immensely to the success recorded in immunization. He lamented that the commitment and transparency so evident was lacking completely in Nigeria hence the poor immunization status in Nigeria. He discussed the usual strategies of: (i) Access, (ii) Utilization, (iii) 'RED' approach as the strategies adopted by Tanzania to achieve this level of success adding that all political groups have immunization as part of their political agenda.

The functions of UNICEF are stated to be

- Procurement of tetravalent Vaccines
- Supply of Cold chain equipment
- Capacity Building.

The following were recognized by UNICEF as challenges:

- Inadequate availability of human capacity
- Lack of Skilled health workers in the rural areas
- The challengers donor support poses for sustainability
- Weak ICC
- Increasing burden of the HIV/ADS.

According to the UNICEF Country Rep, the success of the Tanzania immunization services can be attributed to the following

- Credible Political Structure
- Government commitment to immunization
- Social stability/ peace
- Committed community
- Transparency
- Good communication network

- Sustainability plan being put in place
- Infrastructures in place

World Health Organization, Tanzania

Presenter Dr Cornelia A Atsyor (EPI Consultant/Advisor for WHO in Tanzania)

The main focus of the visit was to know

- The contribution of WHO to the success of routine immunization in Tanzania and their general overview of the Programme in Tanzania including challenges, constraints if any, and way forward.

- WHO assessment of EPI in Tanzania

The presenter is familiar with the immunization services in Nigeria due to 2 past exposures to the Nigerian system that is first to assess EPI Programme and secondly to monitor NIDS in 2004 respectively. She said that immunization activities have been successful in Tanzania due to several factors including:

- The Health Reform in the Country
- The Social Political Structure of the country
- Efficiency of Service Delivery
- Complete/efficient Data Management System
- Country maximizes the contribution of partners
- Efficient monitoring system: Accountability and Responsibility in financial Management

ACHIEVEMENT

- Tanzania has RI coverage of 98%
- Tanzania has already fulfilled condition for certification
- Very high level of awareness about RI by mothers
- Avery high level of Committed workforce
- An integrated dense surveillance structure in place

CHALLENGES

- Inadequate quantity and quality of staff for RI
- Heavy dependence on donor funding by the Government

LESSONS LEARNT

- There is a very efficient system in place
- High level of donor confidence attracts more donor funding
- Workforce is very committed
- Vertical system of governance reduces bottlenecks

EC DELEGATION, TANZANIA

Presenter: Henriette Kolb (Programme Officer for rural development and governance)

The main focus of the visit to the European commission delegation to Tanzania was to know the contributions of the European Commission to health and specifically to immunization in Tanzania

She explained that

- Health is not a focal sector within the European Commission in Tanzania and at the same time not even part of non-focal sector.
- European Development Funds for Health reach Tanzania through Global Fund Budget lines only.
- As there are no funds that are flowing specifically to the Health Sector in Tanzania, European Commission in Tanzania is not contributing to the basket funding system which was establish 2001 as common plan for donors
- European Commission takes part in the monthly meetings of the partners.

It is noteworthy that most of the development partners met with in Tanzania gave a good impression of the quality of MDG cooperation of Tanzanian officials with partners.

MOROGORO DISTRICT 1st September 2005.

Visit to the Morogoro Region

Presenters:	------------------	(Regional Commissioner)
	David Mfwangavo	(Regional Administrative Secretary)
	Grayson W Kikwesha	(Regional Asst Administrative Secretary)
	Dr Meshack M Z Massi	(Regional Medical Officer)
	Mrs Esther Lauwo	(Regional Asst Admin Sec Social Services)

The Morogoro region has a population size of 1.9 million with an area of 73,039 sq kilometers divided into 6 districts. The region is headed by a regional commissioner who is a political head and appointed by the president. The Regional commissioner is assisted by Regional Administrative Secretary (RAS) under which are Regional Assistant Administrative Secretaries (RAAS) who head the administrative clusters.

These clusters are

- Social services cluster under which is Health, water, education
- Physical planning/infrastructure which takes care of road, electricity etc
- Economic support/development cluster which takes care of Agriculture, corporations, livestock development etc
- Regional Local Government cluster which plays advisory roles
- Management cluster which takes care of administration and Human Resource issues
- Planning cluster

Under the Regional Assistant Administrative Secretary for the social services cluster is the Regional Medical officer.

The main focus of the visit to the regional office was to see how immunization services is linked with the regional administrative services and to know the role of the regional government in immunization..

The immunization coverage for all VPD in the region is as high as 93%. The region has a hospital with a capacity of about 330 beds and a health center of about 300 beds capacity which is able to take in patients. Immunization forms a major component of the social services sector.

There exist councilors heading the LGAs who are elected from each ward in the district and are paid monthly sitting allowances only. Decisions are reached and passed forward through a sub-committee existing in councils; this makes the operation of the bottom-up approach easy.

REGIONAL HOSPITAL (Regional Health Management Team) RHMT

Presenters:

Dr M Massi	(RMO)
Jackson Muija	(RCCO)
Margaret Wapalila	(RRCHO)
Anna Gutapahi	(RNO)
Mrs Maro	(DRCHO)
M Kasuku	(RNO)
Dr N C Kanyika	(ROC)

The main focus of the visit which included a short visit to the municipal clinic was to:

- To compare the Structure of the RHMT with other RHMTS.
- To have an overview of the immunization service delivery.
- To see and compare Regional Health Facility, Staffing and Infrastructure to that of other regions.
- To inspect and know the status of the regional cold store
- Understand the system of vaccine storage and distribution to the Districts.

OBSERVATIONS:

- The Morogoro RHMT structure is the same as that of Dar-es-salaam and indeed the entire regions in the country.
- That the cold chain system was well maintained.
- That vaccine distribution is based on vaccine forecast using the push and pull system.
- That Private Public partnership was not so much emphasized as was the case in Dar-Es-Salaam region
- Staff Training is a part of the health system in Tanzania.

LESSONS LEARNT

- Staff development is functional to productivity.
- Maintenance culture is necessary for the success of any programme.
- Community and households contribute to the provision of immunization services.

Debriefing by Change Agents to the Officials of the Ministry of Health, Tanzania

The debriefing was based on:

- Observation of the Socio-Political Structure
- Observation of the Health Structure
- Recommendations for improvement

In Attendance

Dr ------------------	(Permanent Secretary MOH)
Dr ----------	(Ag Permanent Secretary MOH)
Dr R O Swai	(Ag Chief Medical Officer MOH)
Dr E P Mungongo	(Acting Director Hospital Services)
Nsachris Mwamwaja	(Communication Officer)
Joseph Mgaya	(DG, Medical Stores Department)
C Ugullum	(Director Food and Drugs Administration)
Dr Mutahyabaruag	(Director, Human Resources)
David Manyaba	(Deputy EPI Programme Manager)
Nuru Abdullahi	(Chief Accountant)
Barthlomayo Ngaeje	(Director, Preventive Services)

SOCIAL - POLITICAL STRUCTURE OF TANZANIA

We learnt that Pre 1964 there were two countries, Tanganyika and Zanzibar.
By the good efforts and actions of the father of the nation, Mwalim Julius Nyerere, the two countries merged to become the Republic of Tanzania with the capital in Dar es Salaam.
However we learnt that it was a confederal arrangement whereby Zanzibar still keep control of some aspects of Government e.g. her own President, national flag and national anthem, her own parliament.

We learnt that the Political system is multiparty, unitary parliamentary system with elected president and vice president through universal adult suffrage.

Elections of the president and the parliamentarians are held every five years.

We learnt that there will be one in October and the campaign is ongoing. We saw campaign trains and posters. The ruling party is CCM.

There are also elections at the Local Government level for the Councilors who implement Gov. Policies and programs.

We learnt that the Region and District government leaders are appointed by the President. The Regional and District commissioners are political leaders and RAS and DAS all appointed by the president.

Prime minister is appointed by the president and approved by the parliament. He takes charge of the parliament which is headed by a speaker elected from among the parliamentarians

Ministers are the political head of Government Ministries and deputies are appointed by the president also. Ministers do have a Deputy Ministers.

We a learnt that the population is 34,569,232 from the 2002 census with a growth rate of 2.5%
There are 26 regions in the country, 121 districts in the mainland.

The central government is concerned with policy development, Monitoring and Evaluation and support supervision of the regions and districts, security, foreign affairs, currency and finance, coordination of donor and development partners and other common services while the regions interpret central governments policies and programs for implementation by the district and local council.

The region also coordinates the districts and gives them support supervision.

We learnt of the existence of strong community organization, sensitization, mobilization, ownership and partnership in government program. The households are grouped in 10 cells structure with the cell leaders constituting the MTAA. The Mtaa chairmen are actively involved in communication to and mobilization of the community for government program and activities.
We learnt of the existence of several (about 120) local ethnics groups and about 12 languages but Swahili is universally spoken as a national language in addition to English being the official language.
We saw that the use of the language has enabled the citizens not only to understand each other but to live harmoniously thus engendering nationalism.

We learnt that government revenue / income comes through taxes, tourism, yield from agriculture, gold mining and support from development partners.

Main Religions: Christians and Muslim

HEALTH AND IMMUNIZATION SERVICES IN TANZANIA

The health system of Tanzania and the corresponding immunization services are organized along the structure of the Government of Tanzania. The health system thus follows the tier structure of Government at the central, regional, district and sub-district levels.

At the central level, the health system operates through the Ministry of health, which has the following roles and responsibilities.

- Health policy formulation, review and legislation.
- Monitoring, Evaluation and supervision and regulation.
- Resource mobilization
- Co-ordination of donors.
- Data interpretation and analysis.
- Provision of (tertiary) health services through the 4 National Hospitals.

The Regional Health system operates through the Regional Health Management team (RHMT) with the following roles and responsibilities:

- Policy interpretation for the lower levels (districts and sub-districts).
- Monitoring, evaluation and supervision of the lower level health systems/facilities.
- Data collation from the lower levels
- Service delivery through the hospitals (secondary)

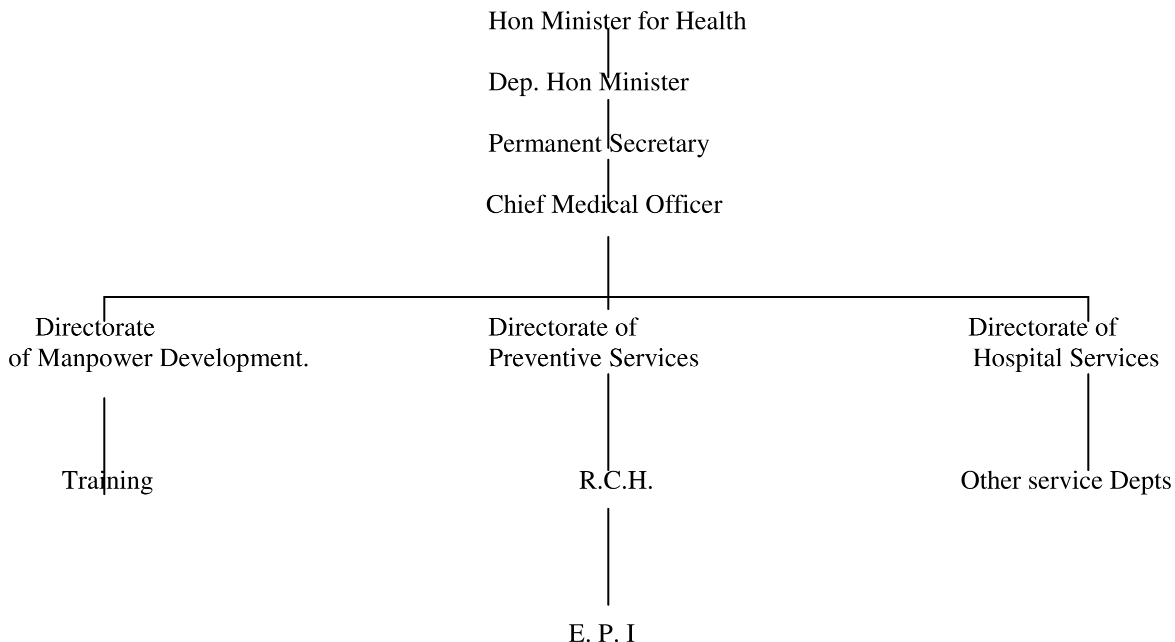
Similarly, the District Health system operates through the District health Management Team (DHMT). DHMT carries out the following functions:

- Health Planning
- Implementation of Health policy.
- Data Collection
- Provision of services through health facilities and dispensaries

The last tier in the health system is the sub-district health system, which operates through the health dispensaries. Their roles and responsibilities include:

- Provision of health services
- Data generation.

At the apex, the Ministry of health has the following administrative structure.



Immunization services in Tanzania are very strong, effective and efficient (which is the reason Tanzania was chosen for the study tour). In our short visit to Tanzania (specifically Dar-Es-salaam and the municipality of Temeke) the story is that of success. In order to have a balance view, we also visited the hinterland of Morogoro district municipal and rural (Mikese).

In all these places, we interviewed and inspected and observed health providers, health facilities administrators and storage facilities. The story of huge success was pervading. The information collected from the above sources was verified and were corroborated by all the three development partners we visited: UNICEF, E.U and WHO.

The National immunization coverage in Tanzania, we found out very high, varying from 80% to 90% for all vaccines. The figures are higher for Dar-Es-Salaam ranging from 87.5% for OPV to 98.6% for BCG and VIC A in 2004. This indeed is highly commendable.

What makes this success more fascinating is that it has been achieved despite the lean structure of the EPI in terms of manpower. Immunization is a public good. E.P.I Central level – policy, planning, procurement and logistics, supportive supervision esp. for under performing regions/districts, Monitoring and Evaluation Technical support for Regional training district

STRATEGIES FOR E.P.I. IMPLEMENTATION

EPI is being implemented as an integral part of reproductive and child Health (RCH). Following the WHO resolution on Universal Child Immunization, you have implemented the EPI programme with increased vigor and over 90% of your health facilities now provide immunization services. Other strategies include outreach and mobile services and through providing static clinics with essential supplies and equipment. Other important strategies are social mobilization and multi-sectoral approach, which include the political parties, Local Government, community Development and Education. PHC committees from regional to village levels have sustained the multi-sect oral approach in implementation and supervision of immunization activities

The success story of immunization cannot be complete without mentioning the Medical Stores Department (MSD). MSD has performed its functions of vaccines and other supplies and equipment procurement, storage and distribution creditably well. It distributes commodities to the regional and district levels.

GENERAL OBSERVATIONS

It was noted that there is

- Political stability
- A strong sense of Nationalism
- Language unity
- High community awareness, sensitization and ownership
- Widely distributed health infrastructures
- Support from donors in form of funding and technical support due to transparency
- Reward system for staff commitment not monetary rather more emphasis on promotion
- Vaccines are procured against 2 years.
- Dispensaries extensive network is valid**.** After Arusha declaration, it was decided to go into the community.
- Staff at lower level trained specifically for targeting the services at the lower level.
- integrating RCH with immunization gives rise to minor mis-understanding

Recommendations by Change Agents to the Ministry of Health, Tanzania
These were the recommendations by the Change Agents to the ministry officials

- That the Government should strive to provide an exit strategy in the form of a sustainability plan in case of donor withdrawal
- That there should be improved and more standardized training for the health workers to meet up with their peers internationally
- That the government should try to preserve the "jamaa" system and the stability of the present political dispensation and be careful with the current open market and capitalism being introduced.
- That the MSD could be given more autonomy and whatever profit being made presently could be plowed into capital investments
- That the country can take advantage of the many types of cooperation schemes existing between African states e.g. the Technical Aid Corps Scheme.

Team consolidation sessions during the tour

Major Comparisms between Nigeria and Tanzania

1. **DEMOGRAPHIC/POLITICAL SYSTEM**

ISSUE	NIGERIA	TANZANIA
Location	Western Africa	Eastern Africa, made up of Mainland Tanzania and Zanzibar
Regions	36 State + FCT	26 Regions
Total Area	924 , ---,--- sq Km	946,569,232 sq Km
Population	150million	34.5 million
Annual Growth Rate	About 3.4%	About 2.8%
Ethnic Groups	More than 350	More than 120
Languages	English is official language with 3 major languages and about 500 other languages	English is the official Language with Swahili being the Universal language and about 12 others
Religion	2 major (Christianity and Islam)	2 Major(Christianity and Islam)

Levels of Government	Federal-State-LGA	Central-Regional-District
System of Government	Operates a Federal system of government (multiparty) Has been under military for over 30 years of her existence since independence in 1960.	Unitary system (multiparty) Never had military Rule Uni-party democracy in the past
Ruling Party	PDP	CCM
Administrative	36 states + FCT 774 LGAs	26 regions 126 districts
Political Structure	Nigeria is a federation and practices the federal system of government. There are 3 levels of government in Nigeria- Federal-State-Local Government. Each of these tiers of government enjoys autonomy. Election is through a Democratic process at all levels. There is also the Executive, Legislative and the Judicial arms of Government. The President is the Chief Executive and Commander-in-Chief of the Armed forces assisted by the Vice President. Ministers are appointed by the president but approval is by the senate. There are 2 legislative chambers, the Senate and House of Representatives whose members are elected The senate is headed by the Senate President while the House of Representatives is headed by a Speaker. Under the ministers, there are Permanent Secretaries, followed by Directors, Deputy Directors, and Asst Directors etc. The state is headed by an elected Governor who is the Chief Executive of the state. He is assisted by the Deputy Governor. Commissioners are appointed by the Governor with the approval of the State House of Assembly which is headed by a speaker. Each Administrative cluster is headed by a commissioner and assisted by state Permanent Secretaries who is the administrative head and the Chief	There are 3 levels of government in Tanzania- Central-Regional-District. The central Government is headed by an elected president who is the Chief Executive and Commander-in-Chief of the Armed forces. The President also presides over the cabinet and is assisted by a Vice-President. There is also a Prime Minister who is the administrative leader of the parliament and is appointed by the President with the approval of the Parliament. Ministers and vice ministers are appointed from the Parliament by the President and the Speaker heads the Parliament. Ministers are political heads of ministries while the Permanent Secretary is the Administrative head and Chief Accounting Officer. They are assisted by Directors, Deputy Directors etc The Regional level is the De-Centralization of the Central government which is headed by a Regional Commissioner being the Political Head, followed by the Regional Administrative Secretary and followed by Regional Assistant Administrative Secretaries who act as heads of the various administrative clusters. All Regional heads are appointed by the Central government. On the structure of the District level, there is the District Commissioner who is appointed by the President, who heads the district council whose members are elected but

	Accounting Officer. These are assisted by Director, Deputy Directors, Assistant Directors and others The Local Government is headed by an Executive Chairman who is elected. Ward representatives who are called Councilors are also elected. The chairman however appoints supervisory councilors with the approval of the Local Government Council	have no executive powers, with the District Executive Director as head of council. There is also elections at the village level where a leader known as the Mtaa is elected as community head to represent each community at the district council

2. **ECONOMIC SYSTEM**

ISSUE	NIGERIA	TANZANIA
Revenue: National	-Oil export -Non oil export -Taxes	-Taxes -Tourism -Agriculture
State	-Allocation from Federation account -Taxes -Investment	-National allocation
LGA s/District	-Allocation from Federation account -Taxes at LGA level	-National Allocation -Taxes

3. **HEALTH SECTOR STRUCTURE AND MANAGEMENT**

ISSUE	NIGERIA	TANZANIA
FEDERAL	Minister of Health Department /units Federal Parastatals	Minister of Health Department/units
STATE	Autonomous State Commissioner for Health Departments	Not Autonomous Regional Commissioner Regional Administration

	State Health Boards	
LGAs	Autonomous PHC Coordinator	Not autonomous
Hierarchy	Federal/State/LGAs	Unitary
Supervision	Independent by each level of government	From National to the Region and to the District level

4. **HEALTH FINANCING**

ISSUE	**NIGERIA**	**TANZANIA**
Federal/National	Federal government Budget 100% for vaccine procurement and distribution to the state level. Occasional donor support in areas of technical assistance and logistics Federal government subventions are available to tertiary Health institutions in each of the states. Who are allowed to augment their budgets through user fees.	Central Government budget ----% for vaccine procurement but relies on Common basket fund comprising of Donor funds For distribution, logistics and other Technical support
State/region	States provide fund for implementation The states are responsible for secondary level of care. State Hospital also charges user fees for services.	Allocation from common basket fund.
LGA/District	LGAs are responsible for the funding of primary Health care services, which include the provision of funds for the collection of vaccines from the states cold stores. User fees are also for non EPI	Basket fund User fee

	services	

5. IMMUNIZATION SUB SECTOR

ISSUE	NIGERIA	TANZANIA
Federal	Immunization programme is a Parastatal under the Federal Ministry of Health headed by a National Coordinator/Chief Executive Officer with Six departments (Policy formulation, Planning, Budgeting, Supervision Monitoring and Evaluation, Vaccine procurement, Resource generation) Recruitment is done at the National level with a staff strength of about 300	Immunization programme is a Unit under Reproductive and Child Health in the Ministry of Health headed by EPI Manager. And assisted by National Cold Chain Officer, Training/ Social Mobilization Officer, National Surveillance/MES Officer, Administrative Manager and other support staff with a lean staff strength at central level of 16
Zonal Structure	Distributed into 6 Zones Zonal Coordinators Zonal cold chain Officer Complement staff.	No zonal structure
State/Region	The immunization Programme at the state level is run as an integrated programme under the Primary Health Care and overseen by the NPI manager. The state is responsible for the recruitment of staff, Planning and Supervision of the LGAs	EPI unit is integrated with other RH&CH services at the region under a regional Health Management team headed by a Regional Medical Officer Regional Cold Chain Officer is responsible for coordination of EPI services in the region
LGA/District	Integrated into the PHC State NPI Manager supervises and monitors.	Integrated with RH&CH at the district level. Supervised by the District Health Management Team The District Cold Chain Officer is responsible for the coordination of EPI activities in the district
Funding	Federal Budget State Budget LGA Budget	Central Budget, Basket funds and cost sharing

Vaccine Procurement	Federal Government through UNICEF	Huge progressively increasing budget by the Central government and procurement through UNICEF Donor support
Cold Chain and Logistic	Federal, State, LGAs and Partners	Partners and government
Vaccine Distribution/Cold chain system Source of Power supply	Push and pull system PSVD in some states Electric/solar powered refrigerators Electricity main source (erratic) Use of generators, gas & solar as back up Maintenance done at each level by Federal, State, and LGAs (Ineffective at the lower level)	Push and pull system Supply from the National to the region done by the Medical Stores Department (MSD) Electricity as the main source of power (steady power supply) -LPG refrigerator -Solar powered as back ups Maintenance done at the district and regional level by trained maintenance team (Effective at all Levels)
Programme Management	National, State, LGAs programme managers	Managed through Dept of preventive Health at the National level Integrated at the regional level Effective supervision at the regional and district level
Human Resources	Responsibility of each tier of government	Similar
Social Mob	All levels	All levels Greater community participation and awareness
Data Management	All levels	All levels

REPORT OF TANZANIA 2 POST STUDY TOUR WORKSHOP
December 2005

I. Introduction

The post tour workshop was organised for participants who went on a Study Tour to Tanzania. It was to harmonise strategies and lessons they learnt during the tour into action for Nigeria. It was also to discuss intended proposals submitted by participants for funding by EU Prime as means to improve immunization coverage and data management in Nigeria

The workshop was held at HERFON Conference Room on the 8th and 9th December 2005, attended by participants from Tanzania Two and Zambia tours, a few staff from HERFON and the EU PRIME Team from Abuja. *(See annex1for list of participants)*

Dr. Ibrahim Oloriegbe facilitated the workshop, assisted by Nahgwa Rebecca (Research officer) in absence of Dr. Ben Ayene. The Objectives and aims were

- Fostering further interaction and group dynamic among the Tanzania Change Agents and between them and other Change Agents
- Identification of lessons learnt from Tanzania Immunization Programme that are relevant to Nigeria
- Developing "Project Proposals" for implementation on some of the issues identified that may lead to positive changes in Nigeria Immunization Programme
- To develop strategies on how to utilize the change Agents programme to sustain the aims of EU PRME Activities in the Six States thus strengthening Routine Immunization services

II. Participants experience during the tour

Before the sessions, it was accepted that setting some binding roles was important to make the sessions a conversational ground and more of a dialogue. Amongst some of the key rules set up by the group, it was generally accepted based on the belief that;

- Nobody knows everything
- Nobody knows nothing
- Everybody has something to give
- Everyone has something to take

Participants recounted and shared some of their individual experiences about the political, economic, financial and health systems structure especially their concerns and strategies of immunization coverage in Tanzania. In a presentation of Tanzania Health System the facilitator emphasized the need for change agents to put into practise the main lessons learnt from Tanzania in their proposals for adoption in the Nigeria context. The experiences are as contained in the study tour report.

Below are some peculiar experiences and lessons learnt while in Tanzania

Political /Economic structure

- The system of government is similar to Nigeria in being Multi party democracy but it is a unitary system of Government with the President elected through Universal Sufferage of all Adults
- The president appoints a Prime Minister who is approved by the parliament. He also appoints Ministers and deputy members from among the paliamentarients
- Has a confederation of states but with two presidents with one representing the country officially
- Is smaller in population and size than Nigeria with about 35 million with less that 120 Ethnic group in about 928sq m.
-

Has 26 regions, 426 districts made up of Mtaas (a community of 10 cells with each cell having a leader for 10 households)

Lessons leant

- Political commitment to immunization health care
- The formation of Mtaas to champion immunization in communities
- Positive attitude, disciplined and committed health workers in their service provision
- Well structured of the health departments in the ministry of Health (MoH)
- Preventive health services
- Availability of facilities
- Cold chain management

In summary there is

- Right message
- Availability
- Commitment
- Affordability
- Quality services

Zambian Experience

Dr. Issa. Mohammed (Commissioner or Health, Gombe) and a representative of the Zambia study tour highlighted Zambia as a country with

- Two seasons, centrally concentrated population large number of educated people
- 95% Christians and 5% Hindus
- Currency name is Kwacha
- Eight Provinces, 72 districts
- Comprises of a National board of health
- Like Mtaa, there is a neighbourhood health Committee
- A basket fund used for provision of logistic requirement in the health service
- Well trained staff and Committed health workers
- Integrated Immunisation services
- Has a supermarket/shopping system of health like the Tanzania's Integrated Child Health Service
- Created awareness to the Zambians
- Good health facilities compared

Lesson learnt from Zambia

- Linkage of health facilities at all levels
- Integrated health system
- Good health facilities and Efficient staff

III. Proposal presentation

Five proposals were presented *(See annexe 2)*

1. Miss Iquo Bassey *"Immunisation Service Delivery in Hard to Reach Areas: A strategy to increase immunization coverage in Cross River State*"

2. Dr. Ajao's "*Vaccine distribution in Osun state"*

3. Dr. Chukwuma *" Involving private health sector providers in RI service delivery: A strategy for improved immunization coverage in Abia State*

4. Mrs. Martha Kibadua *"Involving private health sector providers in RI service delivery: A way to achieve improved RI coverage in Plateau State*

5. Dr. I. M. Umar *"Improved routine immunisation services through functional neighbourhood in Gombe State" (To be developed)*

All the proposals were subjected to debates/comments by participants making them to require for adjustments and fine turning of strategies and activity plans to achieve set objectives. Date lines were agreed for submission of adjusted versions of proposals to EU PRIME and HERFON offices.

Some adjustments were mainly on definition of terms, targeted regions and LGA, selection criteria, Strategies for service delivery, sustainability, budgeting, logistics, time frame etc.

However, the facilitator further highlighted the importance for change agents to write achievable proposals with realistic budgets following their activity outlines.

IV Strengthen Change Agent Effectiveness in states

Dr. Oloriegbe emphasised the need to sustain and strengthen change in states. It was agreed that:

1. Change Agent should get link through state teams,
2. EU PRIME / HERFON should documents guidelines for project implementation to change Agents.
3. Organise a Change Agent Movement through
   - 3a Organise State meetings every 3 months. Change Agents were asked to suggest dates of their state meetings, inviting new members (15) who can readily be available to champion Immunization issues in the State and people with key offices in the health sector to implementing reforms in states who should already be change minded. This should be a volunteer programme
   - 3b Organise National meeting, this will take place in Abuja

4. Work towards a Change Management Training programme for all the EU-PRIME Change Agents
5. Effort be made by change agents towards implementing a proposal in a State as an impact for the study tour
6. Intra country tour to be commenced next year 2006

V. Agreed dates and expectations from Participants on key issues

Proposal to be submitted by

1. Imoke Bassy 23rd December 2005
2. Dr. Ajao 23rd December 2005
3. Dr. I.M Umar 15 December 2005

Scheduled of meetings with (EU PRIME/HERFON team visit)

1. Mrs Martha Kibadua 13th January 2006
2. Dr. Chukuma 19th January 2006

Submission of guidelines

Rebecca, Koms and Helen 15th December 2005

Expected Dates for State Change Agent meetings (with 1st quarter 2006)

1. Abia ?
2. Gombe ?
3. **Plateau 15th February 2006**
4. Cross Rivers ?
5. Ekiti ?
6. Kebbi ?
7. Abuja (National meeting) ? *(will depend on the dates of state meeting)*

Three more trips may be embarked upon next year and one of which maybe outside Africa. Uganda Study Tour may come up in the first quarter of 2006.

Achievements of the workshop

a) Integrated services - Super market approach
b) RI awareness
c) Community Ownership
d) Trained personnel must not be necessarily educated
e) Political commitment
f) Discipline, honesty and attitude change
g) Making use of the WARD group in Nigeria - Mtaa in Tanzania

According to Mr. Moore, EU PRIME Team Leader, study tour is to translate the experiences He encouraged Change Agents to make use of the available resources and lesson learnt.
The workshop came to a close at 3:00 pm on Friday 9th December 2005