Somalia polio outbreak update

For the Polio Eradication Independent Monitoring Board
- October 2013 -

Somalia Ministry of Health
WHO/UNICEF – Somalia
1. Epidemiology update
2. Outbreak response activities
3. Impact of outbreak response activities
4. Additional activities
5. What is next?
History of WPV circulation, Somalia

Districts with WPV cases, 2000

Districts with WPV cases after re-introduction from 2005 2007

- WPV
- Non Polio AFP

Re-introduction

Circulation interrupted

Last indigenous case
2013 WPV update*

On May 2013, a WPV case was notified from Somalia, from a 32 months old girl, date of onset 18 April 2013, resident of Hamar Jabjab district in (Mogadishu)

From its epicenter in Mogadishu, the outbreak expanded to the other districts of South and Central Somalia and more recently to the Somaliland and Puntland

* Data as of Sept 20, 2013
WPV outbreak and accessibility

- Since 2010, 40 districts in South and Central Somalia are completely or partially inaccessible for immunization activities because of insecurity.
- An estimated one million children < 10 years reside in these districts, making Somalia the host of the highest pool of geographically concentrated unvaccinated children in the world.

<table>
<thead>
<tr>
<th>District accessibility status</th>
<th>Number of districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccessible districts</td>
<td>27</td>
</tr>
<tr>
<td>Accessible districts</td>
<td>61</td>
</tr>
<tr>
<td>Partially accessible districts</td>
<td>12</td>
</tr>
<tr>
<td>Accessible districts with security challenges</td>
<td>9</td>
</tr>
</tbody>
</table>
A shift in the outbreak is observed, from Banadir early in the outbreak, to other accessible and inaccessible districts of South and Central. No WPV case was reported from Banadir since Epiweek 29.

Data as of 20 Sept 2013
The month of July saw a decrease in WPV cases reported from accessible districts and an increase in the number of WPV from inaccessible districts.
Proportion of zero-dose AFP

- Overall, 80% of all OPV doses among AFP cases aged 6-23 months are provided through SIAs, translating the insufficiency of routine EPI to reach eligible population.

- The proportion of zero-dose OPV among AFP cases varies from 14-25% in accessible districts to 25-80% in inaccessible or partially accessible districts.
Outbreak response activities

- Immunization response
- Special strategies (Village polio volunteers, permanent vaccination post)
- Advocacy, social mobilisation and public information campaigns
- Interagency/partner coordination
- Human resource surge
The first immunization response targeted 360,000 <5 children in 16 districts of Banadir, a week after the notification of the WPV case.

A 6-month emergency response plan was established with support of WHO, UNICEF and CDC to guide the outbreak response activities for the rest of 2013.

A quarterly assessment of the response activities was conducted in August 2013.

* First immunization response in 16 districts of Banadir and Afgoi
### Immunization response

<table>
<thead>
<tr>
<th>Round</th>
<th>Date</th>
<th>Campaign type</th>
<th>Area</th>
<th>Target</th>
<th>Target pop</th>
<th>Admin coverage (%)</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1</td>
<td>14 - 17 May</td>
<td>sNID</td>
<td>16 districts of Benadir</td>
<td>Under 5</td>
<td>367,206</td>
<td>96%</td>
<td>tOPV</td>
</tr>
<tr>
<td></td>
<td>15 - 18 May</td>
<td></td>
<td>Afgoye district</td>
<td>Under 10</td>
<td>90,862</td>
<td>87%</td>
<td>tOPV</td>
</tr>
<tr>
<td>Round 2</td>
<td>26 - 29 May</td>
<td>sNID</td>
<td>16 districts of Benadir</td>
<td>Under 10</td>
<td>34,413</td>
<td>93%</td>
<td>bOPV</td>
</tr>
<tr>
<td></td>
<td>26 - 29 May</td>
<td></td>
<td>Other accessible areas of South and Central regions + Puntland</td>
<td>Under 5</td>
<td>927,641</td>
<td>84%</td>
<td>tOPV</td>
</tr>
<tr>
<td>Round 3</td>
<td>12 - 18 June</td>
<td>NID</td>
<td>16 districts of Benadir</td>
<td>All ages</td>
<td>1,800,000</td>
<td>77%</td>
<td>bOPV</td>
</tr>
<tr>
<td></td>
<td>12 - 15 June</td>
<td></td>
<td>Other accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 10</td>
<td>1,447,154</td>
<td>91%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 4</td>
<td>1 - 6 July</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 5</td>
<td>616,852</td>
<td>108%</td>
<td>bOPV</td>
</tr>
<tr>
<td></td>
<td>1 - 4 July</td>
<td></td>
<td>Puntland + Somaliland</td>
<td>All ages</td>
<td>5,453,915</td>
<td>74%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 5</td>
<td>21-25 July</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 5</td>
<td>616,582</td>
<td>109%</td>
<td>bOPV</td>
</tr>
<tr>
<td></td>
<td>25-29 July</td>
<td></td>
<td>Puntland + Somaliland</td>
<td>All ages</td>
<td>1,707,365</td>
<td>97%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 6</td>
<td>18 - 21 Aug</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 10</td>
<td>3,440,533</td>
<td>96%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 7</td>
<td>15 - 20 Sept</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 10</td>
<td>3,440,533</td>
<td>96%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 8</td>
<td>20 - 26 Oct</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>All ages</td>
<td>8,538,175</td>
<td>96%</td>
<td>bOPV</td>
</tr>
<tr>
<td>Round 9</td>
<td>17 - 20 Nov</td>
<td>NID</td>
<td>All accessible areas of South and Central regions + Puntland + Somaliland</td>
<td>Under 5</td>
<td>1,707,365</td>
<td>97%</td>
<td>bOPV</td>
</tr>
</tbody>
</table>
| Round 10| Dec         | CHDs          | All accessible areas of South and Central regions + Puntland & Somaliland if funding allows | Under 5 | 1090783 + 616852 = 1707365 | bOPV, Measles along with Vit A, Albendazol and ORS |}

- 10 rounds of NIDs and SNIDs will be implemented from May to December 2013 in all accessible districts of Somalia. High administrative coverage reported for completed rounds.
- Two rounds of all-age-group vaccination conducted in the 16 districts of Mogadishu and nation wide. A 3rd round nation-wide, all-age-group vaccination planned for October 2013.
## Independent Monitoring

<table>
<thead>
<tr>
<th></th>
<th>June Banadir IM (No. of under-5 checked =6522)</th>
<th>August Banadir IM (No. of under-5 checked =4051)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Under-5 finger-marking coverage</strong></td>
<td>82%</td>
<td>65.4%</td>
</tr>
<tr>
<td><strong>Awareness of the campaign</strong></td>
<td>85%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Selected reasons for missed children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Child/parent not available</td>
<td>18%</td>
<td>30%</td>
</tr>
<tr>
<td>Team did not visit house</td>
<td>8%</td>
<td>28%</td>
</tr>
</tbody>
</table>

- Implemented Independent Monitoring for the first time in the 16 districts of Banadir region in June 2013
- In August 2013, IM was conducted in 29 districts
  - 14 districts (12 in Banadir regions) had coverage <80%, country team investigating drop in coverage
- In September 2013, IM was conducted in 39 districts in all the zones
Vaccine Supply and Logistics

- WPV outbreak detected, only polio vaccine in Somalia was tOPV (cVDPV outbreak occurring for the past several years)
- 1st campaign used tOPV, rapidly received bOPV vaccine and repeated campaign in short-term interval in Banadir region
- Changing epidemiology (adults affected) caused last minute changes in vaccine needs to target all age groups, but demand was met quickly and efficiently by global polio supply chain
- Potential logistical issues of vaccine distribution into the regions in SCZ were mitigated by use of chartered flights
- Challenges of increased vaccine and transportation needs were met by global donor community
- Cold chain improvements underway; short-term local procurement was used to supply vaccine carriers/coolers for rapid campaign implementation
Communication for Development: Percentage of Awareness

Percent Household Awareness By Region

Data from intra-campaign rapid assessments
Communication for Development: Percentage of Awareness

Increased HH reached, community dialogues, involvement of leaders (religious, community) and sound trucks by 1.5x

Data from intra-campaign rapid assessments
Communication for Development: Percentage of Awareness

Average across 4 regions, 4 campaigns = 87%

Data from intra-campaign rapid assessments
Improving immunity profile in inaccessible areas

• Vaccination of all children < 10 visiting health facilities and nutrition sites
  – So far 3 inaccessible districts have started
  – 21 districts discussion are ongoing with local authorities through NGOs

• Deploying vaccination teams at major transit points to vaccinate children going to and coming out of inaccessible districts and border countries
  – 251 of the 300 transit points are functional as of 20 September
What has been the impact of the response?
Impact of immunization response (Banadir)

Banadir, The epicenter of the outbreak shows impact of SIAs. No new WPV cases reported in Banadir for more than 8 weeks
The outbreak is still very active in other districts of South/Central Somalia, fuelled by new cases from partially accessible and inaccessible districts.
Mass Media

- In areas like Banadir, Lower Juba and Bay with radio stations these are used to increase awareness levels.

<table>
<thead>
<tr>
<th>Mass Media*</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio Stations used</td>
<td>80</td>
</tr>
<tr>
<td>PSAs aired</td>
<td>48,000</td>
</tr>
<tr>
<td>People reached through SMS</td>
<td>1,300,000</td>
</tr>
</tbody>
</table>

* NGO partner output reporting from SCZ, 6 regions (exc. Gedo)

Note: SMS/Mobile messages <1% in Lower Juba, 0% in others
TV/Newspapers <1% in Lower Juba, 0% in others
Social Mobilization and Advocacy

- **Social Mobilisation:** In Bakool and Gedo with no radio stations, intensified use of social mobilisers and megaphones.

<table>
<thead>
<tr>
<th>Social Mobilization Activities*</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community meetings/dialogues</td>
<td>46,337</td>
</tr>
<tr>
<td>Villages reached through megaphones</td>
<td>536</td>
</tr>
<tr>
<td>Social mobilizers trained</td>
<td>1,242</td>
</tr>
<tr>
<td>Mosque announcements</td>
<td>1,356</td>
</tr>
<tr>
<td>People reached through SM</td>
<td>1,071,682</td>
</tr>
</tbody>
</table>

- **Advocacy:** meetings and launches were conducted with emphasis on community and religious leaders.

<table>
<thead>
<tr>
<th>Advocacy Activities*</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and religious leader meetings, launches</td>
<td>6263</td>
</tr>
</tbody>
</table>

* NGO partner output reporting from SCZ, 6 regions (exc. Gedo)
Additional activities
Special strategies: Permanent vaccination posts (PVP) at cross border and transit points

- Close to 300 permanent vaccination posts were identified at locations in the country, 240 are functional
- An estimated 50000 to be reached per day through permanent vaccination posts
- Transit points established at key passage points between districts (bus stations, airports, check-points, markets, hospitals, etc..) and at international borders (cross-borders, check points, airports etc..)

<table>
<thead>
<tr>
<th>Zone</th>
<th>Planned PVP</th>
<th>PVP functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>116</td>
<td>116</td>
</tr>
<tr>
<td>South</td>
<td>76</td>
<td>62</td>
</tr>
<tr>
<td>Somaliland</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>Puntland</td>
<td>54</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
<td>251</td>
</tr>
</tbody>
</table>
Other ongoing activities and achievements

- **Improved micro-planning**
- **Use of social data collected from SIAs to improve Soc/Mob**
- **Staff surge**
  - Joint WHO/UNICEF organogramme
  - 40 new local staff hired for zonal and regional polio positions
  - 13 new international staff
  - 400 village polio volunteers to be recruited to support polio activities at village level (advocacy, active case search, NIDs)
  - Technical support by international staff from UNICEF (local and international position), WHO, CDC
- **Resources for outbreak response**
  - Adequate and timely resource provision for outbreak response (financial, logistics, vaccines)
- **Coordination**
  - Polio control room coordination established in DoH, WHO, UNICEF
  - Weekly coordination meetings with all partners
  - Weekly conference calls with Headquarters and field staff
  - Cross-borders meeting with Kenya
  - Involvement of NGOs
Accessibility remains a challenge

Immunity profile remains low in inaccessible areas (ban to conduct SIAS) and poses a risk to the timely control of the outbreak.
Communication Challenges

• Inadequate staffing at lower levels to enable support supervision of the community mobilisers.
• Inadequate consistent data collection and analysis to enable evidenced planning and strategy development.
• Limited capacity of social mobilisers in reporting and data collection.
• Fatigue among the community due to the many campaign rounds.
• Inconsistent communication that takes place only during the campaign periods.
• Funding for Social Mobilisation interventions beyond 2013.
What is next?

• A quarterly outbreak assessment mission conducted in 18-27 August 2013 by a joint team
  – Identified strengths and challenges to the control of the outbreak
  – Proposed a set of recommendations to be addressed to improve outbreak control activities

• The outbreak response plan for 2014 is being updated, taking into consideration the recommendations of the Quarterly Assessment Mission

• Focus will be on: improving SIAs quality, maintaining high quality AFP surveillance, improving community adherence to OPV, strengthening advocacy at all levels, improving cross-border coordination.
What is next? (Con’t)

• **Strengthen evidence based implementation** through conducting of studies and consistent IM.

• **Improve the quality of social mobilisers** through training and equipping them with reference materials.

• **Consistent interventions** between and during rounds to increase awareness and reduce refusals. Roll out the public information strategy developed.

• **Strengthen DoH**: Establish/strengthen DoH structures at regional and district level to enable supervision, reporting and data.

• **Integration** of polio messages with WASH and nutrition.
Thank you
EXTRA SLIDES
Social mobilization and communication for development

Streamlining engagement of C4D partners:
DOH/UNICEF joint partner vetting exercise carried out and partners selected based on geographical area they work in, capacity and previous work done. An MOU between DOH and partners prepared and signed.

Streamlining media engagement: vetting of radio and TV channels based on reach, audience credibility, technical capacity carried out. Endorsed by DOH and MOU prepared and signed, expanded from simple PSA to programming. Extra support to streamline media interventions.

Technical support to DOH: recruitment of Polio C4D staff to be based in Mogadishu UNICEF office and one in each of the Ministries of Health.

Hired third party monitoring firm: to follow up actual implementation of planned activities mainly in the less accessible locations.

* Advocacy: High level advocacy including president and beyond the line ministries. Included MoE, MoRA, MoF.

* Launches: For increased visibility and awareness were conducted up to district level.

* Mass Media: Increased number of radio stations to 25 (15 of them in Banadir).

* SMS: High level negotiation through Government with the phone company that has the widest coverage in Mogadishu (Homoud) and they agreed to send out bulk messages. So had two companies on board.

* Social Mobilisers: To increase penetration linked mobilisers to vaccination teams in all the three zones.
OUTBREAK: MAY TO PRESENT

• **Integration of Messages:** based on experiences from other countries, WASH and Nutrition messages have been incorporated in the existing polio messages.

• **Strengthening of community mobilisers:** Training for the social mobilisers has been increased to 5 days, the manual is being revised with the help of the India office. A flip chart with the integrated messages for use during community dialogues is being developed.

**Staffing**

- Recruited C4D Specialist - P3- (on board Mogadishu)
- Recruited C4D Officer – NOA- (DOH and UNICEF Mog)
- Polio Communication Consultant- STOP- (Puntland)
- Hired an institution for third party monitoring – (on board and first report produced)
- Media expert to support Mass media programming – (Part of the surge team for three weeks)
SCZ: Households visited/studied

No. of hholds

Lower Juba  Bakool  Regions  Bay  Gedo

R1  R2  R3  R4
Average(%) sources of information on the campaign for all the 4Rds
Average(%) Reasons for children missed for all the 4Rds

- % child/parent not available
- % no team visited household
- % child asleep
- % New born
- % Religious
- % child sick
- % Fatigue
- % Rumour
- % No demand

Regions: Lower Juba, Bakool, Bay, Gedo
Recommendations for social mobilization

• Conduct study to strengthen evidence based planning.
• Training social mobilisers: Train and equip social mobilisers with materials to use for dialogues.
• Continuous and consistent interventions: For sustained behaviour change communication activities should be implemented on a continuous basis and not campaign mode.
• Strengthen DoH: Establish/strengthen DoH structures at regional and district level to enable supervision, reporting and data.
• C4D staffing: One NOA in DOH, one international in each zone and another at USCC to enable coordination.