

**18th Meeting of the Expert Review Committee (ERC)
On Polio Eradication & Routine Immunization
in Nigeria**

Kaduna, Nigeria

10 - 11 September 2009

Executive Summary

The ERC considers that the progress being made in the polio eradication effort, noted at their last meeting in April 2009, is being sustained in Nigeria. Progress is evident at the national and state levels and in many LGAs. The engagement of political and traditional leaders has been pivotal in achieving this progress.

Since the 17th ERC Meeting the most important epidemiological development has been the decline of WPV1 transmission in very high risk and high risk northern states, which is now at the lowest level recorded since reliable surveillance began. The outbreaks of WPV1 in southern and north-central states have significantly slowed. The extensive transmission of WPV3 in northern states in the first half of the year peaked in March and has been declining steadily ever since, and the high levels of cVDPV transmission in the first half of 2009 have recently begun to decline following the first tOPV round in May, with incidence dropping in both June and July.

The ERC notes that the IPD monitoring data, and data on the immunization status of children, is consistent with the improving epidemiological picture, **and concludes that the reduced transmission of WPV in Nigeria in 2009, particularly the reduction in WPV1, is the result of reaching more children with immunization.**

While the time frame for stopping transmission cannot be defined with absolute certainty, the ERC believes that **if oversight by political, government, and traditional leaders is strengthened, the improvements in quality of IPDs are sustained and expanded, an aggressive schedule of IPDs is maintained through 2009 and 2010, and if there is appropriate use of all types of OPV including bOPV**, the interruption of all three serotypes by mid 2010 is an achievable goal, and one the programme should aim for.

The progress currently being achieved must be consolidated and accelerated through 2009 and 2010 to ensure that polio eradication in Nigeria is completed. The ERC continues to warn strongly against any diminution of effort; while understanding the pressures polio eradication places on national and state governments and partners, **only the completion of eradication can bring the full benefit of all the efforts made to date.**

Major Recommendations:

1. *Very High Priority States:* the states of Zamfara, Kano, Katsina, Jigawa, Borno, and Yobe all still have more than 30% under-immunized children (less than 3 doses of OPV). Despite improvements in several of these states, they are important risks to stopping poliovirus circulation. These states are urged to reach all children during IPDs.
2. *Government oversight and commitment:* the ERC urges the Federal Government and State Governments to continue to take a very high profile on polio eradication. State Governors are urged to hold to the Abuja Commitments, to report back to the President according to the agreed timelines, and to make every effort to ensure the engagement and accountability of Local Government authorities.
3. *Engagement of traditional leaders:* the national programme and partners should continue efforts to fully engage traditional leaders in polio eradication activities,

and to build on the significant progress made in recent months. Traditional leaders are urged to monitor polio eradication activities and in particular to do all they can to ensure all children are reached with OPV during IPDs.

4. *IPD Schedule & Choice of Vaccine:* given the current momentum in the national and state-level polio eradication effort, the ERC recommends that sub-national IPD rounds be carried out in October (using a mix of mOPV3 and tOPV) and November (using bivalent OPV, or if not yet available, mOPV1). Two national IPDs and two sub-national IPDs should be carried out in the first half of 2010. Bivalent OPV offers important advantages in Nigeria and should be introduced as soon as it becomes available.
5. *Enhancing IPD Quality & Coverage:* State Governors are again urged to convene meetings of LGA Chairmen of the identified high risk LGAs, and of any LGA with more than 10% of wards with > 10% missed children, immediately prior to the recommended October and November IPD round, to review past performance, identify problems, and decide on solutions. As a standard response, in any ward where monitors find more than 10% missed children following an IPD round the activity should be repeated.
6. *Community Mobilization:* A plan should be developed to take key interventions to scale to address non-compliance and increase community demand in all high risk wards by January 2010. A particular focus should be on the role of traditional leaders in facilitating quality of services and increasing demand at the community level. The plan should include monitoring, reporting and evaluation mechanisms.
7. *National Financing:* the Government should continue to maintain a rolling 12 month planning timeframe for the intensified effort that is needed to stop transmission of WPV. In particular financial planning should ensure that government contributions are made available in a timely way and in the committed amounts.

Introduction:

The 18th Expert Review Committee for Polio Eradication and Routine Immunization was convened from 10-11 September 2009 in Kaduna State, six months after the previous meeting in April 2009. The 17th ERC meeting had been the most encouraging for some time, with evidence of progress in addressing previous ERC recommendations, and clear signs that for the first time in more than 2 years, polio eradication in Nigeria was beginning to regain momentum.

The ERC was welcomed by the Executive Director of the NPHCDA, who reaffirmed the commitment of the Government of Nigeria to strengthen routine immunization and eradicate polio. The Executive Director posed key questions to the ERC:

- Given the evolving epidemiological situation, when can the programme realistically expect to stop transmission of wild poliovirus and cVDPVs, both geographically and by serotype?
- How can the different OPVs be most optimally used in order to achieve interruption of WPV1, WPV3, and cVDPVs?
- What level of supplementary immunization activities will be required in the remainder of 2009 and 2010 to ensure that all poliovirus transmission is stopped?
- What concrete steps can be taken to strengthen routine immunization while pursuing polio eradication and SIAs?

The ERC was very pleased to have representatives of all states participate fully in the meeting. Representatives of partner agencies also attended.

This report summarizes the main findings, conclusions and recommendations of the 18th meeting of the ERC.

Report on the 17th ERC Recommendations:

The ERC noted the report on the status of implementation of the 17th ERC recommendations. As with the recommendations of the 16th Meeting, the ERC believes that considerable energy has been displayed by the national programme and partners in trying to address recommendations. Significant progress has been achieved against several recommendations, including improvements in the immunization status of children particularly in Kaduna and Sokoto which were tagged as under performing in the April meeting, engagement of political and traditional leadership, implementation of flexible strategies in IPDs, and improved use of monitoring data to identify high risk areas. Less progress has been achieved in the implementation of LIDs, and the prioritization of high risk LGAs for activities to accelerate routine immunization. However, in general the ERC believes that the previous 6 months have seen a sustained effort to address programme shortcomings.

Report on the Abuja Commitments

The ERC received a report on the progress in achieving the Abuja Commitments entered into by all the State Governors of Nigeria in February 2009. Progress in some areas has been significant, with the most substantial compliance with the commitments in endemic states. The ERC welcomes this progress but notes the gaps against the indicators that still exist, particularly with respect to engagement of LGAs, and particularly the relative lack of compliance with commitments in southern states.

Current epidemiological situation:

Surveillance data is virtually complete up to the end of July and the ERC has considered the full period from January to July in assessing epidemiological developments. These developments must be considered in the light of timing of vaccine use in IPDs, and the priority placed on stopping transmission of WPV1 as the most transmissible and dangerous of the three serotypes.

As at 3 September a total of 376 WPV cases with onset in 2009 had been reported in Nigeria, 71 due to WPV1 and 305 due to WPV3, in twenty-six states, compared to 648 cases (597 WPV1 and 51 WPV3) in 22 states for the same period in 2008.

Over the 6 months since the 17th ERC Meeting there have been significant further epidemiological developments. First, WPV1 transmission in very high risk and high risk northern states has declined to the lowest level recorded since reliable surveillance began. Second, the outbreaks of WPV1 in southern and north-central states following importations from the endemic states in 2008 and early 2009 have significantly slowed, although new states were infected as recently as June. Third, the extensive transmission of WPV3 in northern states in the first half of the year peaked in March and has been declining steadily ever since. Fourth, cVDPV transmission rose significantly in the first half of 2009, and has only recently begun to decline following the first tOPV round in May, with incidence dropping in both June and July.

Wild poliovirus type 1 in endemic states:

Following the 2008 outbreak and the extensive control activities implemented in northern states in 2008 and 2009 to date (4 mOPV1 rounds and 2 tOPV rounds between November 2008 and August 2009), WPV1 case numbers have dropped significantly in the endemic states. While 9 of these states have reported at least one WPV1 case in 2009, the total number of cases to date is only 15. Most encouragingly, **the previously highest burden states for WPV1, Kano, Katsina, and Jigawa, have reported no WPV1 cases since February 2009.** The most recent cases have been reported from Sokoto and Zamfara in May, and Kebbi and Borno in July. While it is of course far too early to determine if this decline in incidence will be sustained in coming months, **this is the lowest WPV1 transmission in the endemic states since reliable surveillance was established.**

Wild poliovirus type 1 in north central and southern states:

The spread of WPV1 from endemic states into north central and southern states resulted in sporadic cases and outbreaks of WPV1 in several states. In 2009 to date 56 WPV1 cases have been reported from these non-endemic states. The worst affected states have been Ogun, with 12 cases, and Delta, with 7 cases. In addition to NIPD and sIPD rounds with mOPV1 and tOPV, mop-ups have been carried out in some southern states using mOPV1. The most recent transmission in the south (cases with onset in June and July) has been in Bayelsa and Ebonyi, which have only recently been re-infected, and in Delta which has been reporting cases since early 2009. The most recent transmission in the north central has been in Benue in July, in an area bordering Ebonyi. Month on month the onset of WPV1 in re-infected states has been dropping, and since the start of May only 12 cases have been reported from these areas. During that period no cases have been reported by the previously heavily affected south-western states.

Wild poliovirus type 3:

The extensive outbreak of WPV3 in northern states accounts for nearly 80% of all WPV cases in Nigeria in 2009. More than 60% of WPV3 reported is from just three states, Kano, Bauchi, and Katsina. Kano alone accounts for one-third of the WPV3 cases in Nigeria in 2009. It should be noted that type 3 containing vaccines were used only in January (mOPV3), May (tOPV) and August (tOPV); and the impact of the August round is not yet reflected in epidemiological data. However, the concentration of cases in the high burden states point to large pockets of children unreached by routine immunization or by the January 2009 mOPV3 round. While not preventing the upsurge in cases, the mOPV3 round and subsequent tOPV round in May have had an impact. Since April WPV3 incidence has been declining; by July monthly incidence had dropped to below one third of the average incidence from January to May.

Circulating VDPVs

Transmission of cVDPV type 2 increased significantly in the first half of 2009. It should be noted that type 2 containing vaccines were used in IPDs only in May and August in 2009. Despite this the outbreak has remained confined to northern states with occasional spill over cases in north central states. VDPV transmission has been overwhelmingly concentrated in Kano, Katsina, and Zamfara, which together account for 60% of all cVDPVs reported. Jigawa, Borno, and Niger account for another 20% of the total. There is a significant concentration of cases in key high risk LGAs, with nearly 60% of cases occurring in just 30 LGAs, most of which are in Kano, Katsina, and Zamfara. These LGAs are frequently also infected with WPV and as noted in previous ERC reports, represent significant concentrations of under immunized children. Following the tOPV NIPD in May, incidence has declined month on month in June and July. Data is not yet available to assess the further impact of the August tOPV SIPD.

Geographic Risks

The main geographic risk for continuing transmission nationally remains the endemic northern states. Zamfara, Kano, and Katsina pose the greatest risk, both because they currently carry the greatest burden of both WPV and cVDPVs, and because they still have high proportions of under immunized children - despite improvements in both Kano and Katsina, in all three states around 50% of children have received less than 3 doses of OPV. Significant risks are also posed by Borno and Yobe, not just for transmission within Nigeria, but because traditionally they are the route for exportation of Wild poliovirus to neighbouring countries to the north and east; Zamfara and Sokoto have played a similar role for countries to the north and west.

In the non-endemic southern states, the situation in the most recently infected states, Bayelsa and Ebonyi, will need to be carefully watched to ensure that the outbreaks do not continue. Delta state poses the greatest risk of continuing transmission in the south as it has now been reporting cases for over 7 months. In the non-endemic north central states, most states pose a risk of continuing transmission in 2009; the movement of nomadic populations along the river lines poses risks for extensive virus movement.

Conclusions and Recommendations

In framing its conclusions and recommendations the ERC has attempted to address all of the questions posed by the national programme.

At the 17th Meeting in April 2009, the ERC noted that the situation of polio eradication in Nigeria was more encouraging than it had been for several years. The ERC is very pleased to note that overall, these encouraging developments have been sustained over the past six months. **The ERC continues to believe that significant momentum is being developed in polio eradication activities in Nigeria. If this is sustained and expanded, polio can and will be eradicated from Nigeria.**

Programme developments and their impact on WPV transmission:

The ERC noted the following major developments:

- **Continued progress in raising political consciousness and visibility on polio eradication by national, state, and local governments.** The signing of the Abuja Commitments by State Governors has given a clear signal of commitment and at the same time provided a framework by which state governments can demonstrate their accountability for polio eradication. While the commitments are not fully implemented in all states and while oversight at Local Government level is still not adequate in many LGAs, a mechanism now exists to engage State and LGA authorities, and monitor their accountability.
- **The re-engagement of traditional and religious leaders.** The discussions on polio at the Northern Traditional Leaders Forum convened by His Eminence the Sultan of Sokoto in June 2009, and the subsequent formation of the Northern Traditional Leaders Committee on PHC delivery with HRH Shehu of Dikwa and HRH Emir of Argungu as Chairman and Deputy Chairman respectively, has been a major step in re-engaging traditional leaders and involving them in the polio eradication effort. Similar efforts are being made in other parts of Nigeria to engage traditional leaders. Their commitment to use existing traditional networks to ensure children are immunized is one of the most encouraging developments the ERC has seen.
- **The evidence of more children being reached with immunization during IPDs.** Monitoring data has shown an overall reduction in the number of wards with less than 90% coverage, from 26% in the January IPD to 16% in the most recent IPD in August. Flexible strategies are being followed to improve IPD quality.
- **The improvement of immunization status of children.** The progress noted in the previous ERC meeting is in general being sustained, with overall improvement in OPV immunization status of children in 2009 compared to 2008. Some states singled out by the ERC at the April meeting have shown significant improvement, including Kaduna and Sokoto, which is extremely encouraging. Bauchi has also improved significantly in 2009. However, in one state, Zamfara, the situation has worsened, and progress in other states, including Kano, has slowed.

The ERC notes that the IPD monitoring data, and data on the immunization status of children, is consistent with the improving epidemiological picture, **and concludes that the reduced transmission of WPV in Nigeria in 2009, particularly the reduction in WPV1, is the result of reaching more children with immunization.**

Potential time frame for stopping WPV transmission

The time frame for stopping transmission cannot be defined with absolute certainty, as so much depends on the quality of immunization activities in each IPD, but the ERC believes that if the improvements being achieved are sustained and expanded, and with appropriate use of all types of OPV including bOPV, the interruption of all three serotypes by mid 2010 is an achievable goal, and one the programme should aim for.

The ERC stresses that the achievement of a mid 2010 goal requires the following:

- **The implementation of an aggressive schedule of IPDs through 2009 and 2010 as the best means of rapidly increasing population immunity**
- **Acceleration of the improvement in quality in IPDs overall and ensuring that all children are reached during IPDs**
- **Increasing the proportion of children with more than 3 doses of OPV above 80% in all states and in all high risk LGAs and sustaining that level**
- **The development and maintenance of a high level of oversight by political, government, and traditional leaders**

While transmission in endemic states will certainly extend into the first half of 2010 even if the quality of activities continues to improve, cessation of all transmission in the non-endemic southern states should be achieved before the end of 2009, provided that appropriate mop-ups are carried out between September and December to deal with any remaining transmission. Similarly, the non-endemic north central states could potentially stop all but sporadic transmission by the end of 2009, if they are included in October and November IPDs.

With the introduction of bivalent OPV, and the rationalization of the IPD schedule that this offers, it should be possible to stop both WPV serotypes and cVDPVs in the endemic states within the same timeframe.

While stopping WPV transmission in Nigeria by the middle of 2010 is feasible, it will be impossible to be confident that all polio is gone for at least 6 to 12 months following the last case, depending on the serotype. **For this reason, and to insure against the possibility of transmission continuing at low levels, the national programme should plan a full set of activities through to the end of 2010.**

Continuing low level transmission in the second half of 2010 will also require an extensive and aggressive series of mop-up responses. If no WPV is reported in the second half of 2010, a less intensive programme of activities can be planned for 2011.

Guarding against complacency

The ERC re-iterates that if quality is not improved and maintained, particularly in the highest risk endemic states, the conditions to stop transmission in 2010 will not be met. At the April meeting the ERC warned that in previous years, periods of significant progress have been followed by complacency, the loss of programme momentum, upsurges in WPV transmission and the spread of WPV to polio-free areas of Nigeria and to other countries. **The progress currently being achieved must be consolidated and accelerated through 2009 and 2010 to ensure that polio eradication in Nigeria is completed.** The ERC continues to warn strongly against any diminution of effort; while understanding the pressures polio eradication places on national and state governments and partners, **only the completion of eradication can bring the full benefit of all the efforts made to date.**

Recommendations:

1. The ERC urges the Federal Government and State Governments to continue to take a very high profile on polio eradication. State Governors are urged to hold to the Abuja Commitments, to report back to the President according to the agreed timelines, and to make every effort to monitor the engagement and ensure accountability of Local Government authorities for reaching every child.
2. The national programme and partners should continue their efforts to fully engage traditional leaders in polio eradication activities, and to build on the significant progress made in recent months. Traditional leaders are urged to monitor polio eradication activities and in particular to do all they can to ensure all children are reached with OPV during IPDs. The involvement of traditional leaders should be monitored by the programme to evaluate impact, and to ensure their inputs are used in the best possible way.
3. The following should be the strategic priorities for polio eradication in Nigeria for the coming months:
 - continuing to improve the quality of supplementary immunization activities in all states but particularly in states with high proportions of under immunized children (Zamfara, Kano, Katsina, Jigawa, Yobe, Borno), with these objectives:
 - reducing the proportion of LGAs with more than 10% missed children to less than 10% in all states in coming IPD rounds
 - increasing the proportion of children with more than 3 doses to at least 80%, and reducing the proportion of children with less than 3 doses of OPV to less than 20%, in all states by the fourth quarter of 2009
 - prioritizing improving coverage in the 92 highest risk LGAs identified by epidemiological and monitoring data, with specific feedback provided to state and national levels on performance in these key LGAs
 - interrupting transmission of all WPV in non-endemic north central and southern states by the end of 2009 through the use of mop-ups with type specific vaccine to deal with any breakthrough transmission
 - interrupting cVDPV transmission at latest by the first quarter of 2010
 - interrupting all WPV transmission in endemic states by mid-2010
 - introducing bivalent OPV to rationalize the IPD schedule, and the appropriate use of bivalent, monovalent and trivalent OPV to ensure that transmission of WPV1, WPV3, and cVDPV can be stopped as rapidly as possible
4. The Government should continue to maintain a rolling 12 month planning timeframe for the intensified effort that is needed to stop transmission of WPV. In particular financial planning should ensure that government contributions are made available in a timely way and in the committed amounts.

Supplementary Immunization Activities (SIAs) Schedule

In developing recommendations for SIAs in the coming months, the ERC carefully considered the questions posed by the Executive Director NPHCDA at the beginning of the meeting, and the activities already conducted in 2009. The recommended SIA schedule reflects the strategic priorities outlined above, and is intended to create high levels of immunity to both serotypes of WPV, and to cVDPVs. It tries also to take

into account likely availability of vaccines. As usual, the recommended schedule should be regarded as flexible enough to be varied if epidemiology demands.

Recommendations:

5. The ERC recommends the following SIA schedule:

2009: IPDs

- October: a sub-national IPD in northern and north central states using mOPV3
- November: a sub-national IPD in northern and north central states using bivalent OPV; if bivalent is not yet available mOPV1 should be used. (This round should be in the second half of November to increase the likelihood of bOPV availability)

Mop-ups

- From September 2009 any WPV1 or WPV3 case in southern or north central states should be responded to by an appropriate and rapid mop-up (minimum state-wide) with type specific vaccine
- From September 2009 any WPV1 case in endemic states should trigger a rapid multi-LGA mop-up response with mOPV1

2010: IPDs

- February: a national IPD round with tOPV
- March: a national IPD round using bOPV
- April: a sub-national IPD, extent depending on the epidemiology but at least including all endemic states, using bOPV
- May/June: a sub-national IPD, vaccine of choice and extent depending on the epidemiology but at least including all endemic states
- Second half of 2010: for planning and budgeting purposes at least two sub-national IPD rounds, extent and vaccine of choice depending on epidemiology; in addition a dose of tOPV should be delivered in conjunction with the proposed national measles campaign in the fourth quarter.

Mop-ups

- From March 2010, any WPV1, WPV3, or cVDPV case in any state should be responded to by an appropriate and rapid mop-up with type specific vaccine; the mop-up round(s) should be timed taking into account planned IPDs, but even if IPDs are being carried out in the affected area at least one additional mop-up round should be implemented.

6. From September 2009 (September onset cases) any LGA in which cVDPV2 is detected should immediately carry out a round of LIDs using tOPV, covering the whole LGA; this should be planned and implemented in the same way as IPDs and closely monitored. A report on these rounds should be provided to the ERC.

7. A rotating buffer stock of three million doses each of mOPV1, mOPV3, and tOPV should be maintained to allow for rapid implementation of mop-ups.

SIA quality

The ERC notes the evidence of improved quality in IPDs and the consequent reduction in the proportion of poorly covered wards, and the improvement in immunization status of non-polio AFP cases. However, significant improvement in quality is still needed particularly in the key high burden endemic states, and this quality must be sustained in all rounds in order to achieve polio eradication.

Recommendations:

8. Building on the recent improvement in the quality of supplementary immunization activities in the high risk endemic states, the proportion of under-immunized children should be reduced to less than 10%, and the proportion of children with more than 3 doses increased to at least 80%, in all states by the fourth quarter of 2009. **Particular attention should be paid to Zamfara, Kano, Katsina, Jigawa, Yobe, and Borno, which still have high proportions of under-immunized children.**
9. The process of forming State and LGA Task Forces should be completed in all participating states prior to the October IPD round.
10. State Governors are again urged to convene meetings of LGA Chairmen of the identified high risk LGAs, and of any LGA with more than 10% of wards with > 10% missed children, immediately prior to the recommended October and November IPD round, to review past performance, identify problems, and decide on solutions. LGA Chairmen should chair daily review meetings during IPDs to ensure problems are identified and addressed.
11. Efforts should be targeted to high risk LGAs and wards; specific interventions in these areas should include coordination with traditional leaders to increase community engagement.
12. **As a standard response, in any ward where monitors find more than 10% missed children following an IPD round the activity should be repeated.** This process should be documented according to a standard format, including the number of children reached in the repeated activity, and summarized for the next meeting of the ERC.
13. Mechanisms for recording and re-visiting households with missed children should be trialled and evaluated in the October IPD to determine if they improve the eventual coverage of missed children.
14. The flexible operational strategies being used to strengthen IPD quality, including independent supervisors and special teams, should continue to be monitored and evaluated to refine strategies to achieve the best possible effect. Experience with these strategies should be well documented and disseminated to state teams.
15. Following IPD rounds, all left over vaccines should be returned to state or zonal level, and documented appropriately to ensure that an accurate picture of stocks is developed, and to ensure that wastage in the system is minimized.

Surveillance & Laboratory

Surveillance quality in general remains good and the ERC considers that adequate information is available to inform programme decisions. The performance of the Maiduguri and Ibadan laboratories remains strong despite the high workload, with further improvements in timeliness in 2009.

Recommendations:

16. The ERC endorses national programme plans to continue to carry out peer surveillance reviews in selected states in order to maintain a high level of vigilance on surveillance quality.
17. Supervisory review visits should be carried out in all LGAs not meeting both surveillance indicators, and the results of the visit documented to ensure that any identified problems are addressed.
18. Laboratory workload and performance should continue to be monitored, particularly in the period of transition in management of the Ibadan laboratory, and following the introduction of real time PCR. Adequate support should be provided to the national polio laboratories to ensure continued high quality and timely provision of results to guide programme decisions.

Social Mobilization and Communications for polio eradication

The communication and social mobilization support for PEI has gained momentum, particularly through the engagement of traditional leadership and the deployment of LGA level consultants / facilitators. Several key activities, including community dialogues, local media and school programmes have been used innovatively and have demonstrated impact, but these interventions remain sporadic and dependent upon state or LGA level initiative. Non-compliance to polio immunization remains (including the possibility of non-compliance manifesting in children being absent during IPDs), especially in key areas of the north east and north west, but experience has demonstrated that with focused interventions at scale, this resistance can be addressed and demand for OPV and routine immunization increased. The national communication support package is poised to roll out, but key activities need to be identified and implemented at scale in high risk states, LGAs and wards.

Recommendations:

19. A plan should be developed to take key interventions (school partnership, traditional leader engagement, community dialogues) to scale to address non-compliance and increase community demand in all high risk wards by January 2010. A particular focus should be on the role of traditional leaders in facilitating quality of services and increasing demand at the community level. The plan should include monitoring, reporting and evaluation mechanisms.
20. Media activities, including radio drama, traditional media and IEC materials development, should be taken to scale to ensure maximum coverage of key polio eradication messages, prior to the November IPDs. Communication messages for

national and sub-national media and IEC materials should be developed based on social data.

21. The interpersonal communication component of the national training package for vaccinators should be reviewed and improved, and this module should be included in all local level training activities to improve the vaccinator capacity to communicate with caregivers, prior to the November IPDs.
22. The national programme should support states to develop mechanisms to better collect and analyze social data, in particular reasons for non-compliance and child absent, and develop interventions to address these reasons for missing children.

Routine Immunization

The ERC considers that recent developments offer great promise for improving routine immunization. The experience of planning and implementing activities to reach every village and every child developed through polio eradication activities can be used to significantly strengthen planning and implementation of routine immunization. There are states, such as Kebbi, that have succeeded in carrying out extensive polio eradication activities while at the same time strengthening routine immunization. In other states innovative methods are being used to ensure availability of funds at LGA level. However as a general rule the opportunities for adopting lessons and innovations for routine immunization are not adequately explored and experience is not made use of. The infrastructure for delivering routine immunization remains weak and incomplete. The ERC feels that the issues facing routine immunization need to be more thoroughly explored before truly useful recommendations can be made.

Recommendations:

23. The next meeting of the ERC should be extended to 3 days, the first two days to cover polio eradication and other accelerated disease control issues, and the third to be a special day concentrating on how the experience of polio eradication can be better used to strengthen routine immunization, and to identify other opportunities to boost demand and delivery. This meeting will be aimed at producing practical recommendations which can be closely monitored.
24. In advance of the special meeting on routine immunization, comprehensive summaries of the current situation on routine immunization should be prepared and shared with ERC members to enable an informed and constructive discussion. These summaries should include the experiences of states that have succeeded in strengthening routine immunization, and any innovative approaches to demand generation and service delivery that are being tried.
25. The ERC notes the results of the Nigeria Cold Chain Inventory and urges that the deficiencies in infrastructure be addressed as soon as possible. In particular the zonal stores should be made fully operational. Progress should be reported to the next ERC.

Measles Control

The ERC notes the epidemiological analysis made by the national programme to inform decisions on the timing of measles follow-up campaigns, and concurs with the conclusions. Given the tremendous impact of preventing measles on child mortality and morbidity in Nigeria, it is critical to maintain a very high level of control over measles disease.

Recommendations:

26. The ERC endorses the national programme proposal to conduct a national measles follow-up campaign in the last quarter of 2010. A dose of OPV and Vitamin A should be delivered with measles vaccine. Other possible interventions can be decided at a later date.
27. The national programme should continue to closely monitor the situation of measles transmission; a regular progress report on measles control should be presented at each ERC meeting.

Maternal and neonatal tetanus elimination

The ERC noted programme plans for MNTE campaign activities. Time constraints reduced discussion on this important topic, and the ERC had received nothing in advance of the meeting to inform discussions. As a result it is difficult for the ERC to make substantive recommendations. However, the ERC points out that MNTE campaigns by their nature tend to be quite different activities to either measles or polio campaigns, in terms of target group and time frame, and this must be taken into account when planning activities.

Recommendations

27. The national programme is urged to review planned MNTE elimination activities in the context of planned polio eradication and routine immunization activities to ensure that there is no clashing of schedules. A comprehensive activity plan will be required in those states planning MNTE campaigns. An update on MNTE should be presented at the next ERC meeting.

Next ERC Meeting

The ERC proposes that its next full meeting to review the situation of polio eradication should be scheduled for March 2010.