

Report

10th Meeting of the Expert Review Committee (ERC) on Polio Eradication in Nigeria

**Kano, Nigeria
12-13 July 2006**

Executive Summary

The 10th Expert Review Committee (ERC) met in Kano on 12-13 July to review progress in Polio Eradication and Strengthening of Routine Immunization in Nigeria.

The ERC reviewed technical reports presented by Directors of Primary Health Care from high-risk states in Northern Nigeria, National Programme on Immunization (NPI) and Inter-agency Coordination Committee (ICC) working groups.

Following their deliberations, the ERC noted that the main objectives of Polio eradication immunization activities in the remainder of 2006 should be to:

- rapidly improve the immunity status of children in the highest risk states and thereby bring WPV transmission down to very low levels by end of 2006
- protect children in polio-free areas by maintaining high immunity and
- focus on highest risk LGAs to ensure better access to children and to ensure that they are immunized.

The ERC noted the significant progress made in strengthening routine immunization during the first six months of 2006, and the increased ownership and community participation at State and LGA levels. The ERC was particularly appreciative to the Government of Nigeria for the transparent manner in which progress and remaining challenges facing routine immunization were presented and discussed.

Summary of main ERC recommendations:

- 1) Immunization campaigns in "the 11 high risk states", should continue to be implemented using the IPD approach comprising
 - (a) combination of fixed sites and house-to-house vaccination teams;
 - (b) provision of routine EPI antigens at fixed sites;
 - (c) provision of additional child survival interventions such as Vitamin A and anti-helminthics in accordance with appropriate time intervals;
 - (d) provision of additional epidemiologically indicated interventions (e.g. Cerebrospinal Meningitis (CSM) vaccine, Yellow Fever (YF) Vaccine wherever available.
- 2) The Supplemental Immunization Activities (SIAs) plan for July-December 2006 should comprise
 - (a) an IPD round in September 2006; if CSM vaccine is available, all 19 Northern States in meningitis belt would be included in this round. If CSM vaccine is not available, the September round would be restricted to 11 high-risk states that participated in May and June IPDs
 - (b) inclusion of OPV vaccine during the October 2006 accelerated measles vaccination campaign in 17 Southern states
 - (c) an IPD round in November 2006 in selected highest risk Local Government Areas based on prevailing epidemiology and

- (d) nation-wide round in December 2006 (with IPD approach in 11 states). Yellow Fever Vaccination would be given during the December round.
- 3) The lessons of the recently conducted IPDs should be taken into account to improve the quality of SIA operations. Specifically
 - (a) all LGA micro-plans should be reviewed in all IPD states
 - (b) the supervisory process should be strengthened from pre-implementation activities (micro-planning, training, selection of personnel, logistics...etc) to implementation of the rounds
 - (c) core process indicators should be identified and used to monitor resolution of common problems experienced during May and June IPDs and
 - (d) operational funds (social mobilization, training, logistics...etc) from both Government and Partners should arrive in time at LGA level.
- 4) The national social mobilization and communication strategy should be finalized and approved by implementing partners.
- 5) Partnerships with religious and traditional leaders and institutions, particularly the Presidential Forum on traditional, religious leaders and the media should continue to be strengthened. Definitive roles and responsibilities of religious and traditional leaders, mechanisms to support their involvement as well as clear monitoring indicators should be defined.
- 6) The ongoing efforts to ensure uniform high quality Acute Flaccid Paralysis (AFP) surveillance should be continued in a manner that would strengthen measles case based surveillance as well as Integrated Disease Surveillance and Response in line with priorities of the Federal Ministry of Health.
- 7) The efforts of the Federal Government of Nigeria to provide adequate supplies of bundled vaccine for Routine Immunization should be sustained. This should be implemented through twice-yearly procurement.
- 8) Expansion of routine immunization services should be linked to overall strengthening of Primary Health Care Delivery. States should monitor availability of trained staff, supplies, equipment and financial resources at health facilities.
- 9) The Government of Nigeria should finalize the plan for capacity building for routine immunization (training of service providers, Mid-Level Managers training) by August 2006. The Government (Federal, States and LGAs) and partners should support implementation of this plan.
- 10) The cold chain rehabilitation plan should be completed by end of August 2006 and gaps presented to the Inter-Agency Coordination Committee (ICC).

1. Introduction

The 10th meeting of the Expert Review Committee on Polio Eradication in Nigeria was convened in Kano on the 12-13 July 2006. The ERC reviewed progress in Polio eradication and strengthening routine immunization and presented expert technical advice to the Government of Nigeria.

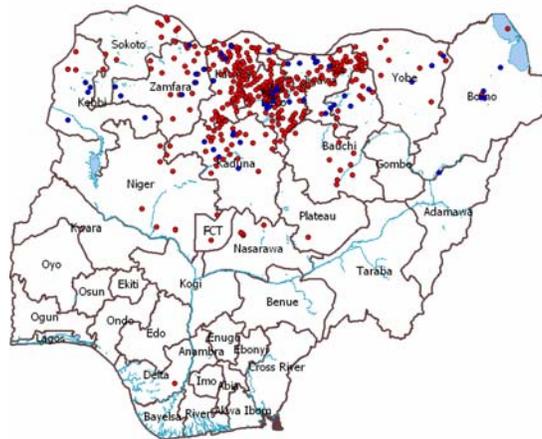
The opening ceremony was presided over by His Excellency Mallam Ibrahim Shekarau, Executive Governor Kano State, represented by His Excellency Engineer Abdullahi Magaji, Deputy Executive Governor Kano State and Professor Eytayo Lambo, Honorable Minister of Health, Federal Republic of Nigeria. Opening statements to the meeting were also delivered by Honorable Commissioner of Health Kano State, Interim Coordinator NPI, Chairman ERC as well as Representatives of UNICEF, WHO and CDC.

This report summarizes main observations and deliberations of the 10th ERC meeting.

2. Status of Wild Poliovirus Transmission

As of 7th July 2006, Nigeria had 531 confirmed WPV cases in 15 states compared to 266 for the same period in 2005 in 18 states. Six states accounted for 85% (Bauchi, Jigawa, Kaduna, Kano, Katsina, and Zamfara) of all confirmed cases in 2006.

Figure 1: Distribution of 2006 confirmed polio cases in Nigeria (as of 7th July 2006)



The persistent wild poliovirus transmission is a result of the poor immunization status in significant proportion of susceptible children i.e. high zero-dose children. As of June 2006, 8 northern states (Borno, Jigawa, Kaduna, Kano, Katsina, Sokoto, Yobe and Zamfara) still had more than 20% zero dose children among non-polio AFP cases aged 6-59 months.

3. Activities and Progress since the 9thERC Meeting

Immunization Plus Days (IPDs): Reports of the IPDs conducted since 9thERC meeting were presented by State Directors of Primary Health Care from nine states as well as by the Operations Working Group of the ICC.

The IPD reports indicated much higher engagement of State and LGA authorities, better social mobilization through community dialogue and improved logistical and operational preparations, particularly during the June IPDs resulting from more timely receipt of operational funds. It was also reported that data from the IPDs was of better quality than the data from previous OPV campaigns.

Several challenges were reported including poor response by vaccination teams in several areas, insufficient supervision and monitoring, poor commitment of several LGA teams as well as non-compliance as a result of side effects of DPT.

The data from the IPDs suggest improvements in access to children in several high risk states. Despite the improved data quality, several state reports had data inconsistencies. It was pointed out that all states should take effort to verify SIA data. The real impact of the IPDs would be demonstrated by surveillance data showing a decline in confirmed polio cases in the coming months.

The ERC noted that it was critical that experiences and lessons learned during May and June IPDs be used to improve the quality of future IPDs, particularly in the lagging States and LGAs.

Social Mobilization: Progress in implementation of social mobilization recommendations of the 9th ERC meeting was presented by the Social Mobilization working group of the ICC. Focus Group discussions and communication strategy workshop were held to adapt social mobilization activities to IPDs.

Community dialogues were promoted and traditional leaders (district heads, ward heads...etc) were tasked with increasing community awareness, resolving non-compliance and enhancing community participation in the campaigns. There was also increased use of town announcers, use of mosque and church announcements and immunization in Ko'ranic schools. Innovations, such as the Child Adoption Scheme, were applied in some high-risk states. School age children "adopted" children in target age group and ensured that their adopted children were immunized during the campaign.

Challenges that were experienced included poor quality of some of the community dialogues conducted, insufficient mapping of political, social and religious networks in high risk LGAs, weak state advocacy plans, DPT side effects and insufficient involvement of some traditional leaders in monitoring the effectiveness of social mobilization activities.

Regarding the way forward, it was proposed that Village and District Health committees should be resuscitated, community dialogues sustained, child adoption scheme promoted, and training materials produced.

Surveillance: Progress in implementation of surveillance recommendations of the 9th ERC meeting was presented by the Monitoring and Evaluation working group of the ICC. The main activities conducted included refresher training of DSNOs, monthly surveillance review meetings at State level, enhanced supervision in 5 poorly performing states and provision of regular monthly surveillance performance feedback to all the states.

Between January and June 2006, All states but 2 (Edo and Rivers) met the target surveillance performance indicators. This is an improvement from the same period in 2005, when 7 states were unable to meet the target performance. (Table 1). During same period in 2006, 74% of all LGAs met main AFP surveillance performance indicators, up from 55% LGAs achieving such indicators in 2005.

Table 1: AFP Surveillance Performance by Geo-Political Zone, Jan-June 2005/2006

Zone	January-June 2005			January-June 2006		
	NP AFP Rate	% Stool Adequacy	% LGA meeting both indicators	NP AFP Rate	% Stool Adequacy	% LGA meeting both indicators
North West	6.8	90	56	13.0	88	70
North Central	8.1	88	66	11.1	88	71
North East	4.9	81	59	11.0	89	78
South West	3.9	95	63	9.2	84	82
South East	4.3	92	50	5.4	90	78
South South	2.9	85	36	5.8	78	62
National	5.1	88	55	6.5	86	74

Both Ibadan and Maiduguri Polio laboratories met all the laboratory performance indicators in 2006. The epidemiology of wild poliovirus transmission indicates a slight decline in monthly confirmed polio cases in April and May 2006 as compared to previous months. The decline in confirmed cases is also associated with a decline in newly infected LGAs.

Routine Immunization: Routine immunization activities undertaken since the 9th ERC included stake-holder consultations, rolling out of Reaching Every Ward (REW) strategy to States and LGAs, training in vaccine management and logistics and implementation of monthly immunization monitoring meetings at State and LGA level. Increases in the number of health facilities providing fixed and outreach immunization services were recorded in many States.

As a result of these activities, national DPT3 coverage increased from 37.5% by end of December 2005 to about 50% by the end of May 2006. The number of states achieving at least 50% DPT3 coverage increased from 6 in February 2006 to 16 by end of May 2006. It was noted that the administrative data on Routine Immunization

required validation. It was also noted that feed-backs on routine immunization performance should be regularly provided to the Governors, key religious and traditional leaders.

Challenges included vaccine stock-outs during the period under review, insufficient capacity of health workers as well as poor functioning primary health care delivery system.

Logistics: Logistics working Group reported that during the period January-May 2006, 95% of LGAs reported BCG vaccine stock-out; 84% of LGAs reported OPV vaccine stock-out; 76% of LGAs reported Hepatitis B vaccine stock-out and 68% of LGAs reported DPT vaccine stock-out.

An updated cold chain inventory and replacement tool had been introduced and was being used. It was reported that an updated cold chain replacement plan would be finalized and presented to the ICC by August-September 2006.

4. Recommendations

The ERC made the following recommendations:

Polio Eradication SIAs

1. Immunization campaigns in selected high risk states, should continue to be implemented using the IPD approach comprising (a) combination of fixed sites and house-to-house vaccination teams; (b) provision of routine EPI antigens at fixed sites; (c) provision of additional child survival interventions such as Vitamin A and anti-helminthics in accordance with appropriate time intervals; (d) provision of additional epidemiologically indicated interventions (e.g. Cerebrospinal Meningitis (CSM) vaccine, Yellow Fever Vaccine) wherever available.
2. The Supplemental Immunization Activities (SIAs) plan for July-December 2006 should comprise (a) an IPD round in September 2006. The scope of this round would be determined by availability of CSM vaccine. If CSM vaccine is available, all 19 Northern States in meningitis belt would be included. If CSM vaccine is not available, the September round would be restricted to 11 high-risk states that participated in May and June IPDs (b) inclusion of OPV vaccine during the October 2006 accelerated measles vaccination campaign in 17 Southern States (c) an IPD round in November 2006 in selected highest risk Local Government Areas based on prevailing epidemiology and (d) a nation-wide round in December 2006 (with IPD approach in 11 states), with the delivery of Yellow Fever vaccines during this round.
3. The ongoing efforts to license mOPV 1 from additional manufacturers should be expedited, to ensure that there is adequate supply for the recommended rounds.

4. The SIAs plan for 2007 should include 2 national rounds and one large scale sub-national round. IPD approach should be maintained in selected states. The first national round should be held as early as possible in 2007. The 11th ERC would further review the 2007 SIA plan.
5. The lessons of the recently conducted IPDs should be taken into account to improve the quality of SIA operations. Specifically (a) all LGA micro-plans should be reviewed in all IPD states (b) the supervisory process should be strengthened right from key pre-implementation activities (micro-planning, training, selection of personnel, logistics) to the implementation of the rounds (c) core process indicators should be identified and used to monitor resolution of common problems experienced during May and June IPDs and (d) operational funds (social mobilization, training, logistics...etc) from both Government and Partners should arrive in time at LGA level¹.

Social Mobilization

6. The national social mobilization and communication strategy paper outlining roles of partners, media support and community social mobilization should be finalized and approved by implementing partners.
7. Partnerships with religious and traditional leaders and institutions, particularly the Presidential Forum on traditional, religious leaders and the media should continue to be strengthened. Definitive roles and responsibilities of religious and traditional leaders, support mechanisms to guide and support their involvement as well as clear process and outcome indicators should be defined.
8. The six highest risk States should develop social mobilization and communication plans to cover a six month period. These plans, which should be finalized prior to the September 2006 SIAs should take into account ongoing and SIA specific activities. These plans should include (a) advocacy outcome objectives, targets, activities and evaluation (b) ongoing community engagement activities and (c) social maps. These plans should be updated before every SIA based on polio epidemiology as well as on the outcome of communication activities.
9. Social mobilization training modules should be developed. Field personnel should have access to these modules prior to the November 2006 IPDs in highest risk LGAs.
10. Data collection and use should improve as part of the planning and evaluation process of all communication activities. Social data should be gathered systematically to demonstrate knowledge, attitude and behavior linked to

¹ 8th ERC recommended that funds for micro-planning, training and social mobilization should reach LGA at least 3-4 weeks before the start of the immunization campaign.

communication interventions and must demonstrate impact of communication activities, including community dialogue.

Surveillance

11. The ongoing efforts to ensure uniform high quality Acute Flaccid Paralysis (AFP) surveillance should be continued in a manner that would strengthen measles case-based surveillance as well as Integrated Disease Surveillance and Response (IDSR) in line with priorities of the Federal Ministry of Health.
12. Laboratory performance should continue to be closely monitored and appropriate support offered where necessary.

Strengthening Routine EPI

13. The efforts of the Federal Government of Nigeria to provide adequate supplies of bundled vaccine for Routine Immunization should be sustained. This should be implemented through twice-yearly procurement.
14. The strengthening of routine immunization should be linked to overall strengthening of Primary Health Care Delivery. States should monitor availability of trained staff, supplies, equipment and financial resources at health facilities, with an aim of having a fully functional health facility (as per national definition) per ward.
15. The Government of Nigeria should finalize the plan for capacity building for routine immunization (training of service providers, Mid-Level Managers training) by August 2006. The Government (Federal, States and LGAs) and partners should support implementation of this plan.
16. The cold chain rehabilitation plan should be completed by end of August 2006 and gaps presented to the Inter-Agency Coordination Committee (ICC). The aim of the cold chain rehabilitation plan should be to ensure that at least 80% of all LGAs have adequate cold chain capacity within next 9-18 months. All cold chain equipment procured should conform to WHO/UNICEF specifications for vaccine storage.
17. The process of reviewing and updating LGA micro-plans for Reaching Every Ward (REW) approach should continue and progress reported to the next ERC.
18. Routine EPI administrative data should be validated, through implementation of Data Quality Self Assessments as well as external Data Quality Audits (DQA). The outcome of the Routine EPI data validation should be reported to the next ERC.

5. Conclusion

The ERC noted that Nigeria had the capacity to stop wild poliovirus transmission quickly and further strengthen routine immunization, if every effort was taken to close quality gaps and reach all children consistently.

6. Date of the 11th ERC

The 11th ERC meeting will be held in November 2006. The actual dates and location will be communicated to members after the dates for the IPD round in November 2006 in selected highest risk Local Government Areas have been determined.