

FINAL REPORT

**24th Meeting of the Expert Review Committee (ERC)
On Polio Eradication & Routine Immunization
in Nigeria**

Abuja, Nigeria

10-11 September 2012

Executive Summary

Nigeria now has the majority of the world's polio cases in 2012, and a 2-fold increase in cases since this time in 2011. Nigeria is the only country in the world where the rate of new polio cases *has increased* since the World Health Assembly declared the completion of polio eradication an emergency for global public health in May 2012.

Encouragingly, however, there is good evidence that programme performance is actually improving in many of the worst performing Local Government Areas (LGAs) which now, for the first time, are achieving coverage of >60% during Immunization Plus Days (IPDs). Most northern states are now approaching the minimum OPV coverage thresholds needed to stop transmission. The crucial challenge is to ensure that performance in the many poorly performing LGAs – particularly in the core 2012 transmission states of Kano, Sokoto, Katsina and Borno – is closely, regularly and publicly tracked to address the fundamental problems they are encountering to reach at least 80% of children (as confirmed by Lot Quality Assurance sampling or LQAs) by end-2012.

The Expert Review Committee highlights three benchmarks that the programme should reach before the end of 2012 to ensure the country is by then on track to stop transmission. First, there is an urgent need to create a shared national and pervasive sense of 'emergency' in the country, particularly within the worst-performing LGAs and states. The *decline* in the number of polio-infected states meeting the Abuja Commitments must be reversed, with all such areas achieving these commitments by November. Secondly, the rate of improvement of polio campaign performance in the worst performing LGAs must be accelerated, with at least 90% of the worst-performing LGAs having LQAs lots accepted at >80% coverage by end-2012. Third, national efforts to strengthen routine immunization must be accelerated, with the finalization of a national immunization strategy and its endorsement by the Inter-Agency Coordinating Committee by end-2012.

Fortunately, there are new approaches and more capacity than ever to rapidly improve IPD performance and to help meet these benchmarks. The ERC applauds the active leadership of President Goodluck Jonathan for the establishment of the Presidential Task Force in response to this emergency and for the increase in federal funding to intensify the polio effort at this time. Traditional leaders continue to demonstrate their solid support for the program and have on 8 September signed a compact committing to improve vaccinator selection and supervision in the worst-performing wards; partner agencies have recruited >3500 additional polio workers for the worst-performing areas; the new volunteer community mobilization network is beginning to persuade 'resistant' families to vaccinate their children; and a new, house-based planning approach is finding chronically missed settlements. The September IPD will be essential for evaluating whether these developments can translate into the step-change in performance needed to reach the 80% threshold for stopping transmission in the worst-performing LGAs, as verified through LQAs.

Recognizing the need for an immediate, further *step-change* in programme effectiveness in reaching chronically missed children in both routine and supplemental immunization, the ERC offers the following major recommendations for urgent implementation through end-2012:

Major Recommendations:

1. *Immediately Implement New House-Based Planning*: fundamental to improving the coverage of both Immunization Plus Days (IPD) and routine immunization, is the full implementation of the new house-based microplanning process initiated in August 2012. LGA Immunization Officers and Ward Focal Points must be directly accountable for the completeness and quality of these plans, which must in term be independently validated by NPHCDA, partners and/or other authorities. This new, grassroots planning process must be fully assessed immediately after the Sept IPD and updated following each round through end-2012.
2. *Optimize the 'Emergency Surge'*: the lessons learned from the new house-based microplanning and monitoring process should be rapidly incorporated into a thorough refresher training for all surge personnel and their supervisors in advance of the October IPD. The NPHCDA should establish by mid-October 2012 the additional professional management capacity needed to track and optimize the inputs and impact of this massive surge effort.
3. *Address the Fundamental Problem of Vaccinator Selection, Training & Supervision*: the new Traditional Leader pact should be fully supported to finally address the chronic problem of vaccinator performance in the worst-performing Wards and LGAs. This must be tracked in the new 'dashboard' that would be reviewed by the Presidential, State and LGA taskforces.
4. *Enhance Understanding of Chronically Missed Children*: the ERC is concerned that the reasons underpinning the high number of chronically missed children are still not fully understood. The programme should have protocols for rapidly conducting social research in the worst-performing LGAs and wards to reduce 'child absence/non-compliance' through more targeted social mobilization efforts and improved vaccinator performance.
5. *Intensify oversight of the National Emergency Plan*: the decline in state level commitments to polio eradication, and continued gaps at the LGA level, as reflected in the recent Abuja Commitments monitoring report, must be reversed with the active support of the Nigeria Governors' Forum and the Federal Government. The indicators for the proposed 'dashboard' for tracking LGA pre-, intra- and post-IPD performance must be updated immediately to facilitate their oversight and accountability.
6. *Plan for programme implementation in Insecure Areas*: the Government of Nigeria urgently needs a comprehensive plan to access all children if eradication is to be ultimately successful. It is urgent that a proper analysis of the nature and true impact of the insecurity on programme performance, particularly in Borno and Yobe, be completed in October 2012 as the basis for a comprehensive plan to optimize coverage in this vital area. If possible, environmental sampling should be introduced in Maiduguri as part of that plan to facilitate the ongoing assessment of the programme's impact and risks.
7. *Give proper attention to improving routine immunization coverage*: the ERC is alarmed that the failure to even report on routine immunization in this meeting may reflect a lack attention to this fundamental strategy of the eradication

programme. The ERC requests that adequate time and due attention be devoted to this issue at its next meeting.

8. *Plan for a full, intensive IPD schedule beyond end-2012:* recognizing that the recent IPD quality improvements have so far raised coverage to only 60-80% (by LQAs) in the worst performing LGAs, and not above the critical threshold of 80% to stop polio, the Federal and State Governments must plan now for a full intensive polio campaign schedule of 7 rounds (2 national and up to 5 subnational) in the infected states in 2013.

Introduction

The 24th Expert Review Committee for Polio Eradication and Routine Immunization was convened on 10-11 September, 2012 in Abuja. This is the first meeting of the ERC since the 2012 World Health Assembly that declared completion of polio eradication a global public health emergency. The ERC is reviewing the program in the context of increasing reports of polio cases that has made Nigeria the most polio infected country on the planet and the primary threat to a polio free world.

In this context, the ERC was asked to consider the following key questions:

1. What is the significance of the upsurge in polio in Nigeria in 2012?
2. How can mobilized resources and technical inputs be optimized to increase IPD quality in high risk LGAs?
3. How can the additional surge of human resources be optimized to ensure impact and cost effectiveness?
4. How can the program continue to deliver in areas with increasing security challenges?

The ERC was very pleased to have representatives of key states and partner agencies participate fully in the meeting. This report summarizes the main findings, conclusions and recommendations of the 24th meeting of the ERC.

Report on the 23rd ERC Recommendations

The ERC reviewed the report on the status of implementation of the 23rd ERC recommendations and congratulates the national program on progress in implementing some key recommendations. Most notably, the ERC applauds the establishment of the Presidential Task Force by Mr. President earlier this year, Mr. President's strong public commitment to eradicating polio at the Commonwealth Heads of State meeting in Perth, the increased allocation of federal funding to intensify efforts to eradicate polio, finalization of the revised National Emergency Action Plan (rNEAP), and scale up of human resources. It notes that while the national program has committed to fully implementing the recommended SIA schedule, some recommendations remain either not yet done or partially implemented. Future assessments of the implementation of ERC recommendations must be accompanied by corroborative data and additional details in order for the ERC to evaluate the extent of progress towards implementation of its recommendations.

Current epidemiological situation

In 2012, as at 07 September, 84 cases due to wild poliovirus were reported from 11 States compared to 36 cases due to wild poliovirus in 6 States for the same period in 2011. Even though there has been an increase in cases in 2012, the level of virus transmission is not comparable to the widespread multiple hundreds of cases reported prior to 2010. 60% of the cases have been reported from 3 of the 11 states: Katsina (22), Kano (17), and Kaduna (11). Katsina is currently the state with the greatest number of reported polio cases in the world. 42% (35/84) of the cases have been reported in 9 LGAs of northern Nigeria.

WPV1 remains the most widespread of the two WPV types, being reported from all but 2 of the 11 high risk northern states. North-central and north-eastern states continue to allow persistence of WPV3 transmission, which has expanded to 16 cases in 2012 compared to 9 for the same period in 2011. Nigeria has the largest and most biologically diverse type 3 polio transmission in the world.

The most recent type 2 cVDPV2 case was reported in April 2012 and preliminary laboratory results suggest additional cases will be reported with onset in August. This represents a significant decrease in cVDPV circulation and an opportunity for the program to interrupt this long standing outbreak. However, preliminary laboratory results recently reported strongly suggest that further cVDPVs with onset in August 2012 will be reported from Kano state – indicating that the risk of type 2 cVDPV persists and that responsive action is still required.

Program data indicate that IPD quality has improved. An analysis by the research organization Global Good quantified the gains in supplementary immunization coverage achieved by poor-performing LGAs in northern Nigeria over the past 3 years using LQAS data. The results suggest nearly a doubling in estimated coverage from 2010 to 2012 (~27-55% in 2010 to ~54-70% in 2012). However, their analysis also showed that these gains are insufficient to achieve interruption of transmission.

Programme developments

The ERC noted some key developments since their last meeting:

- **Commitment to polio eradication at the highest level of the government of Nigeria.** His Excellency, the President of Nigeria, has established and convened a Presidential Task Force to oversee implementation and monitor progress towards successful interruption of poliovirus transmission in Nigeria. This establishes the benchmark for political commitment and engagement for the entire Nigeria programme. The ERC appreciates the leadership and commitment of the federal Minister of State for Health in chairing the Presidential Task Force and the critical role he plays in forging national consensus to eradicate polio and strengthen routine immunization.
- **New approaches for addressing fundamental challenges to high quality IPDs.** Since the last meeting of the ERC, the national program has laudably focused on the basics, re-examining the fundamental approaches to IPDs. New approaches, such as re-structured teams, house based microplans, traditional leader led repeat vaccination in poor performing wards, and the volunteer community mobilizer network have been implemented and hold the promise to be the platform for comprehensive improvement in IPD quality across the north of Nigeria.
- **A surge of human resources for polio eradication.** There are now more human resources dedicated to achieving polio eradication in Nigeria than at any time in the past. There has been a call for “all hands on deck” to address the remaining challenges and both government and partners have responded.

Conclusions and Recommendations

The ERC carefully considered the epidemiological situation and the programme data in developing its conclusions and formulating recommendations on actions to eradicate polio from Nigeria.

Eradicating polio

Nigeria is the only country in the world that has reported an increase in the number of polio cases in 2012 – a doubling of cases compared to the same period last year and increase in cases in every northern high risk state. **This reversal is an obvious concern to the Government of Nigeria and the global polio eradication initiative.** It not only increases the risk of Nigeria repeating the re-infection of neighbouring polio free countries, many of whom remain vulnerable to polio outbreaks, but also leads the **ERC to conclude that unless Nigeria redouble its efforts, it will be off track to interrupt poliovirus transmission within the next 12 months.**

Despite this sobering situation, the ERC's review of the program identified some encouraging developments that hold the promise of reversing the situation and moving the programme towards success. An independent analysis of LQAS and immunization status data by Global Good provided evidence that gains have been made in increasing OPV coverage in the worst performing LGAs of high risk northern States. The ERC notes that this is consistent with the epidemiology – the program has moved from the period prior to 2010 where many hundreds of cases were being reported across high risk northern states to the current situation where transmission is controlled at a level of around 100 cases. This is a step in the right direction that must be accelerated. **However, the ERC believes that more needs to be done to truly transform the programme to one that can rapidly stop polio transmission.**

Completing polio eradication has been declared a national emergency, though **the ERC finds that the urgency associated with an emergency needs to permeate to the lowest levels of the program, particularly the Very High Risk LGAs and those LGAs where immunity has dropped in 2012.** Complicating matters is the continuing insecurity in many northern high risk states, particularly Borno and Yobe. **The ERC agrees with state government officials that the security situation is a concern that needs focused attention** and one that adds to the urgency of completing eradication.

What is to be done?

The ERC was encouraged by a number of developments in the national program that, if fully implemented, would serve as the **essential ingredients** necessary to **transform a program that is achieving uncertain control to one that will achieve eradication.** Efforts to shift to house based microplans and focus on improving vaccination teams through better selection, training, and intensive real time monitoring are the platform for success that must be rapidly and fully implemented across all LGAs of northern Nigeria. The surge of human resources by the government of Nigeria and polio eradication partners provides the capacity to achieve the required transformation if they are focused, managed, and held accountable. The pact signed by traditional leaders to lead repeat vaccination efforts in poor performing

wards offers a new avenue to bring their influence to some of the fundamental challenges with vaccinators and accountability. The promise of a revised national communication strategy would create an enabling environment for delivering OPV if it can be rolled out in time to support the low transmission season IPDs. Efforts to improve routine immunization in persistent cVDPV LGAs. Finally, under-pinning everything, is the hope that the government can succeed in truly elevating completion of polio eradication to an emergency status at all levels. **The ERC remains convinced that if these things can be done with focus and commitment, Nigeria can rapidly achieve interruption of poliovirus transmission.** The consequences of not doing so are grim. The promise of success - historic.

Recommendations

The ERC requests that the recommendations of the 23rd meeting be taken in conjunction with recommendations of previous meetings which remain valid, and urges the national programme and partners to fully implement pending recommendations from previous meetings.

The ERC believes the program can intensify its emergency response. As a result, its recommendations are framed around what needs to be achieved in the next 6 weeks, 3 months and 6 months.

Augment political oversight and commitment to achieving polio eradication in Nigeria

1. The establishment of the Presidential Task Force and engagement of state governors can be further enhanced and translated to all levels of the high risk states. The ERC recommends:

Within 6 weeks:

- a. an increase in the emergency operations capacity of the national program to manage and report information on progress towards interrupting poliovirus transmission to the Presidential Task Force
- b. Establish a fully functional and timely IPD dashboard for all LGAs of northern Nigeria states

Within 3 months:

- c. re-invigorating the Abuja Commitments through the setting of a target of 100% implementation in all northern high risk states
- d. all Executive Governors and LGA Chairmen in the 11 high risk Northern States visited by the Presidential Task Force to review program priorities and gaps
- e. NPHCDA produces a monthly report that tracks and quantifies actions taken in implementing the Accountability Framework of the National Emergency Plan

Transform the fundamentals of IPDs to establish a foundation for achieving high coverage in SIAs

House based microplans (before the October IPDs):

2. Complete the process to convert all microplans in northern states from a settlement based to house based approach.
3. Establish a process to verify the quality of the new house based microplans in at least one randomly selected ward of the very high risk LGAs and 50% of the high risk LGAs
4. Complete the GIS ward maps in all 8 planned states and use them as an additional method to validate the completeness of the new house based microplans and expand GPS tracking of vaccinator teams to at least 5 LGAs in Sokoto and Zamfara by October and the remaining 4 states by November as an additional tool for program monitoring
5. Ensure that the nomadic microplanning processes are included in the overall microplanning procedures and that resource needs (people, transport, time) are realistically identified to ensure planning, implementation, and monitoring of immunization of nomads and shifts in population due to security challenges or other reasons.

Team selection and training (before the November IPDs)

6. Specify and clearly communicate to the field the process and criteria for team selection by ward selection committees well in advance of the IPD and in sufficient time to provide training and incorporate team names in all microplans
7. Develop and implement a participatory skill based vaccinator training approach that includes a component on improving inter-personal communication skills

Oversight (before the December IPDs)

8. Develop an intra-IPD monitoring process that delivers standardized and actionable data on team performance to the LGA level on a daily basis during evening debriefing meetings
9. Considering the current global limits to OPV supply, establish mechanisms to improve OPV stock management at state and team levels including return of unused OPV

Repeat vaccination

10. The ERC commends the “traditional leaders pact” to oversee repeat vaccinations in poor performing areas. The ERC recommends that the activity be evaluated by the national program after each of the planned repeat immunization activities and that this evaluation provide a frank assessment of strengths and challenges encountered.

Supplementary Immunization Activities (SIAs) Schedule

11. The ERC endorses the SIA plan for the remainder of 2012:
 - a. 3 sub-national rounds with bOPV covering 8-12 high risk northern states one round with tOPV and 2 rounds with bOPV conducted no more than 6 weeks apart with dates for all SIAs fixed before the end of September

12. The ERC proposes the following schedule for 2013 for planning purposes:
 - a. Two national IPDs, one round with bOPV and one with tOPV, in January and February
 - b. Two sub-national IPDs in 8-12 high risk states before the end of May with bOPV.
 - c. Up to 4 additional sub-national IPDs from mid 2013, with the final number of rounds, extent, and vaccine of choice dependent on epidemiology.
 - d. SIAs should be conducted no more than 6 weeks apart and the dates for SIAs in the first 6 months of 2013 should be fixed by end of October 2012.
 - e. This schedule should be reviewed and finalized at subsequent ERC meetings based on the evolving epidemiology.

Mopping up in response to circulating poliovirus

13. The ERC re-emphasizes its past recommendations on mop-ups and the critical role they are expected to play in preventing re-establishment of poliovirus transmission to polio-free states and any area continuing to detect cVDPV2 transmission. It recommends:

Within 6 weeks:

- a. Review current management systems for responding to outbreaks in polio-free states and any area reporting cVDPV2 and put corrective measures in place to ensure that out-break response protocols can be met in 100% of situations

Within 3 months:

- b. Provide a report to the ERC on the programs ability to initiate case investigations within a 72 hour period, convene Core Group meetings within 24 hours of case notification to plan a response, mount an effective, immunization response covering a minimum of multiple LGAs and at least half a million children within 28 days of confirmation; continue subsequent rounds at as short an interval as possible taking into consideration planned IPD rounds; deploying additional human resources to support outbreak areas; engage local government and traditional leaders; and roll-out the accompanying communications for the outbreak

Operating in a complex security context

14. The ERC recognizes the challenges and increasing complexity to successful polio operations that is posed by the security concerns in some parts of northern Nigeria.

Within 6 weeks

- a. As was successful in some other countries with similar challenges, the ERC recommends the identification and hiring of a security analyst that can guide the program and provide an accurate assessment of the operating constraints and make recommendations for addressing the challenges.

Within 3 months

- b. Data on areas / teams that are unable to perform their duties due to insecurity should be systematically collected and compiled into regular reports following each SIA that can be used to monitor and track the

evolving situation. This report should be forwarded to His Excellency, the President by the Presidential Task Force.

Optimizing surge

15. The investment in additional surge human resources needs to be optimized to ensure maximum contribution to program objectives.

Within 6 weeks,

- a. A training package specific to the new surge staff at WHO and UNICEF needs to be developed and implemented. The training should be focused on equipping them with standardized tools and knowledge on supporting microplanning, community engagement, team selection, team training, and monitoring. All 'surge staff' in VHR LGAs should be trained before the October IPDs with all remaining staff trained before the November IPDs

Demand generation through a revised national communication strategy

Within 6 weeks,

16. The national communication strategy should be updated and refined taking into consideration the recommendations of the 2012 Communications Review, with clear milestones for achievement which are linked to the NEAP. It should:
 - a. Have clear, SMART objectives with an explicit focus on reducing levels of missed children – including tracking progress towards reducing children absent from households in addition to progress in reducing resistant households
 - b. take into account the work on risk profile of polio affected children and high risk communities.
 - c. fully integrate work with religious leaders, Tsangaya schools and other institutions, including Haj advocacy, into the national and sub-national strategies in 2012 and into 2013
 - d. Incorporate the development of a simple media crisis plan with clearly defined protocols for dealing with any significant rumour or crisis that may affect the programme including the designation of spokespersons.
 - e. Progress in the national strategy should be linked to the global communication indicators and the NEAP and reported quarterly, with updates against specific milestones shared with the Executive Director, NPHCDA outlining progress, achievements and next steps based on social data and the current epidemiology.

Within 3 months

17. The revised communication strategy should guide the development of an updated operational plan that includes rolling out state and LGA planning and capacity building activities, with specific mechanisms for supporting high risk wards as part of the IWCS. This should include standard protocols and operating procedures for all groups working on communication at Federal, State, LGA and Ward levels.
18. An assessment of the Intensified Ward Communication Strategy, including the evolving Community Volunteer Network and its impact on reducing missed

children, should be conducted in light of the new or refined national strategy. The assessment should include a management review of the VCM, including selection of community volunteers and supervisors, planning, implementation and supervision of activities, training and tools provided to VCMs to fulfill their duties.

19. Social research has a larger role to play in informing polio eradication activities in Nigeria. UNICEF, with the NPHCDA and partners, should lead a review of the social research agenda and develop a methodology for rapid assessment of:
 - a. community and household attitudes towards and demand for polio immunization.
 - b. the role that incentives might play in motivating vaccinators or communities for the program
 - c. The assessments should be done at least once every quarter to track changes and inform the overall messaging and communication activities.

Within 3-6 months

20. A comprehensive mass media strategy should be designed that brings together 1) systematic journalist outreach engagement and capacity building and 2) the proposed branding exercise to improve visibility and ownership of the program and 3) radio and TV programming at state and community level that complements and amplifies the “on the ground” social mobilization efforts

Routine Immunization

21. Higher priority needs to be given to improving routine immunization coverage. The ERC requests that adequate time and due attention be devoted to this issue at its next meeting and that the national program re-commit to fulfilling its commitments outlined in the NEAP.

Within 6 weeks

- a. NPHCDA to provide the ERC with an RI update on Pentavalent introduction and the timeframe and process of finalizing a new national immunization strategy, NPHCDA’s special efforts in 72 LGAs targeted due to poor RI coverage, and a vaccine supply status report.

Within 3 months

- b. NPHCDA and GPEI partners to provide the ERC with a report providing an overview of the current support by the polio program to routine immunization, and quantifiable plans for strengthening polio’s support to RI with quantifiable targets that can be reported tracked by the ERC in subsequent meetings.

Continued improvement to surveillance sensitivity

Within 6 months

22. Intensify active surveillance in northern states through an increase in the network of informers and surveillance sensitizations. The national program is requested to provide a report at the next meeting of the ERC outlining the numbers of additional informers recruited and sensitizations conducted in northern Nigeria states since September 2012

23. Continue expanding the network for environmental surveillance. The sites in Kano should be re-evaluated to determine whether the sites should be relocated to areas that may be more sensitive for detecting WPV. Strong consideration should be given to establishing environmental surveillance in Maidugiri with consideration of how this can be achieved in the current security context. Expansion to Lagos should also be targeted for 2013.

Research & Data Analysis

Within 6 months

24. The planned serosurvey for October in Kano and Kebbi state should proceed and include sampling of older age groups (5-9, 10-14yrs) in addition to <5 year olds with results available by the next meeting of the ERC
25. CDC, Global Good, WHO, and UNICEF work together to update the Very High Risk/High Risk LGA list using their combined risk algorithm taking advantage of the transmission data from the previous 6-9 months and the high transmission season.