

# **Report**

**Of the**

**33<sup>rd</sup> Meeting of the Expert Review Committee  
(ERC)**

**On Polio Eradication & Routine Immunization  
in Nigeria**

**Abuja, Nigeria**

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**33<sup>rd</sup> Meeting of the Expert Review Committee (ERC)  
On Polio Eradication & Routine Immunization  
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## Abbreviations

AFP	Acute Flaccid Paralysis
AVADAR	Auto-Visual AFP detection and Reporting.
bOPV	Bivalent oral polio vaccine
CJTF	Civilian Joint Task Force
cVDPV	Circulating Vaccine Derived Poliovirus
DHIS2	District Health Information System2
DOPV	Directly observed polio vaccination
DVM-MT	District Vaccines and Devices Monitoring Tool
EOC	Emergency Operations Centre
ERC	Expert Review Committee of Polio Eradication and Routine Immunization
EPI	Expanded Programme on Immunization
FCT	Federal Capital Territory
FOMWAN	Federation of Muslim Women Associations in Nigeria
FRR	Financial Resources Requirements
GPEI	Global Polio Eradication initiative
HiLAT	High Level Advocacy Team
IDPs	Internally displaced populations
IPC	Inter-personal Communication
IPDs	Immunization Plus Days
LCCO	Local Cold Chain Officer
LGA	Local Government Area
LIO	Local Immunization Officer
LQAS	Lot quality assurance sampling
MNTE	Maternal and Neonatal Tetanus Elimination
mOPV2	Monovalent oral polio vaccine type 2
NEZ	North East Zone
NIPDs	National Immunization Plus Days
NNT	Neonatal tetanus
NPHCDA	National Primary Health Care Development Agency
NTLC	Northern Traditional Leaders Committee on Primary Health Care Delivery
OM	Outside monitoring
OPV	Oral polio vaccine
PEI	Polio Eradication Initiative
PHC	Primary Health Care
PTFoPE	Presidential Task Force on Polio Eradication
RES	Reaching Every Settlement
RI	Routine Immunization
RISS	Routine Immunization Supportive Supervision
SIA	Supplemental Immunization Activities
SIPDs	Supplemental Immunization Plus Days
SL2	Sabin Like type2
SOPs	Standard Operating Procedures

tOPV	Trivalent Oral Polio Vaccine
VAR	Vaccine Arrival Report
VCM	Volunteer Community Mobilizer
VDPV	Vaccine derived polio virus
VSL	Vaccine Security and Logistics Officers
VTs	Vaccinator Tracking System
WFP	Ward Focal Person
WHO	World Health Organization
WPV1	Wild polio virus type 1

## Executive Summary

After about 2 years of interrupting polio transmission, Nigeria was reclassified as a polio endemic country by the World Health Organization (WHO) in September 2016 following the isolation from AFP cases, of strains of WPV1 and cVDPV2, in Borno and Sokoto States, respectively. Four WPV1 strains were isolated from AFP cases reported in IDP families in 3 LGAs in Borno State - Jere, Gwoza and Monguno, while one AFP case due to cVDPV2 was reported from Sokoto State. Also, WPV1 was isolated from a healthy contact of the Monguno LGA case whose stool tested positive for cVDPV2, with onset on 25 August 2016. In addition, one strain of cVDPV2 was isolated from sewage samples collected on 23 March 2016, in Borno State,

The response to these outbreaks was rapid, aggressive, unprecedented and of optimal quality, attributable to the extraordinary efforts and commitment of staff of the Government of Nigeria and partner agencies. The response entailed frequent short interval quality supplemental immunization activities (SIAs), using different antigens and managing quality under very complex circumstances.

Inaccessibility due to insecurity in Borno and other northeast States remains the key challenge of the polio programme in Nigeria. There is therefore the need for the programme to sustain ongoing initiatives to access children in inaccessible areas, including using satellite imagery and Vaccinators Tracking System (VTS) to estimate populations living or trapped in inaccessible settlements. It is important and essential for government to urgently mount additional effort to ensure unhindered accessibility to these areas, without which it is impossible to even conceive a time frame to the end to polio transmission in Nigeria.

High risk populations including IDP, nomads and mobile population continue to pose significant risk of transmitting poliovirus within and beyond the northeast due to surveillance gaps and inaccessibility. It is therefore imperative that the programme intensify ongoing efforts to improve the quality of SIAs, active surveillance, conduct stool examination of healthy children arriving from inaccessible areas.

While the release of ₦9.8billion by the federal government, following the 2016 outbreak, is commendable, there is still about \$475.5m funding gap for 2017-2019. The evidence of waning political commitment is available for all to see: the Presidential Task Force has not met in the last two years; the release of State and LGA counterpart funding remain suboptimal and many LGA Chairmen no longer participate in the evening review meetings. Since adequate and timely release of required funding is critical to successful implementation of planned SIAs, there is an urgent need for government and partners to bridge the funding gap while Governors and LGA Chairmen demonstrate greater commitment to the polio eradication initiative. It must be clearly stated that with the current state of commitment at the State and LGA levels, the end of polio eradication in Nigeria will be unduly and embarrassingly prolonged.

Despite on-going appreciable efforts to strengthen surveillance system especially in the northeast zone, the presence of polio compatibles, prolonged undetected circulation of WPV1 and cVDPV are indicators of huge surveillance gaps. The high cohorts of un-immunized children and suboptimal RI coverage in some states, including the southern states, indicate low population immunity and vulnerability of many states to possible outbreak of polio.

All the 2016 WPV1 cases are in children in the IDP camps. The four viruses are genetically linked to polioviruses circulating in Borno in 2011, revealing prolonged undetected indigenous transmission. For Nigeria to stop the transmission of WPV and cVDPV2 and maintain population immunity in the rest of the country, government in collaboration with the military and the communities must coordinate every effort required to reach the children in the inaccessible areas with the vaccine.

## Major Recommendations

**Estimate population living or trapped in inaccessible areas.** The ERC notes that inaccessibility in Borno remains a challenge to the Nigeria PEI Programme as almost 50% of the settlements did not report any AFP case during 2016, indicating limited reach of surveillance network in the inaccessible areas. Between 39% and 52% of the settlements were inaccessible during the SIAs held in 2016. The ERC acknowledges the need to access children in the inaccessible areas and therefore urges the programme to continue its initiatives on gaining access, in collaboration with the military and use satellite imagery and VTS data to estimate population living or trapped in the inaccessible areas.

**Enhance surveillance in the inaccessible areas, IDPs and other high-risk populations:** ERC notes that surveillance gaps in inaccessible of populations in IDPs and other high risk areas pose serious risks to the programme as polio transmission within these groups is likely to be missed. It therefore urges the programme to conduct stool examination on samples of healthy children arriving from inaccessible areas, thoroughly investigate all polio compatibles and ensure that AFP surveillance network reaches the nomadic population.

**Internally Displaced Population:** ERC notes that following successful military interventions, there is a continuous establishment of formal and informal camps for displaced and highly susceptible populations from different inaccessible LGAs. The IDPs while posing challenges, offer unique opportunities to vaccinate vulnerable and unprotected children and conduct active surveillance. Consequently, ERC urges the programme to map all settlements and track movement of IDPs and ensure high quality active surveillance and SIAs in formal and informal IDP camps.

**Advocacy and Communication:** ERC is concerned about the waning political commitment at various levels characterized by the failure of the Presidential Task Force on Polio Eradication and Routine Immunization (PTFoPE) to meet for the past 2 years; the late and sub optimal release of counterpart funding by some states and LGAs and poor attendance of evening review meetings (ERMs) by LGA Chairmen. ERC urges that the PTFoPE meets urgently. Perhaps as was done in the past, a high ranking government official, (at the level of the Minister of State), be saddled with the coordination of the function and activities of the PTFoPE. In addition, the programme should develop innovative strategies to increase political support at State and LGA level and increase active participation of LGA Chairmen in Polio activities including attendance at ERMs.

**Funding Gap 2017-2019:** ERC acknowledges the prompt release of ₦9.8billion by the Government of Nigeria in response to WPV1 outbreak in August 2016. However ERC is concerned that there is a funding gap of \$475.5m for 2017-2019 due to planned/expected reduction and availability of GPEI financial resources from 2017. ERC notes that the timely release of all financial resources is critical to stopping polio transmission and the maintenance of population immunity across the country. It therefore urges the programme to embark on advocacy with Government to fulfill its 2017 obligation to contribute N9.8 billion, as per Financial Resources Requirement (FRR), and ensure timely procurement of vaccines for 2017. The partners are also urged to release funds timely, in accordance with the FRR.

**Supplemental Immunization Activities (SIAs) Calendar 2017:** The ERC notes the need to strike a balance between the number of SIAs and the quality of campaigns taking into



consideration the current economic recession in the country and global vaccine availability risks. The ERC therefore urges the program to focus on stopping transmission of WPV1 and cVDPV2, and maintaining population immunity in rest of the country. Consequently, the ERC after reviewing the proposed 2017 EOC SIA schedule of 2 NIPDs and 5 SIPDs, recommends using bOPV for 2 NIPDs and 4 SIPDs in high risk States, with the proviso that the scope of the SIPDs be expanded to involve 18 States as against 14 States, except the February round. The ERC urges the programme to complement the SIAs with in-between round interventions.

**Vaccine Management:** ERC acknowledges the interventions instituted to improve vaccine management but notes that gaps still exist especially at state and LGA levels in terms of vaccine security, accountability and capacity. ERC therefore urges the programme to tighten vaccine supply management and ensure existing stocks are factored into any new vaccine requests and to ensure the return, and the disposal of mOPV2 to maintain zero balance, after the planned January SNID, in accord with global guidelines.

**Emerging risk of VDPV2 and Sabin Like type 2(SL2):** ERC is deeply concerned about the risk of Sabin Like type 2(SL2) isolates particularly as the country has successfully switched from tOPV to bOPV since April 2016 and notes that isolation of VDPV2 and SL2 are indicators of possible population immunity gaps and on-going use of type 2 containing vaccines. ERC urges the programme to address the emerging risk of VDPV2 and SL2 as the latter isolates are reportable under International Health Regulations (IHR), by conducting thorough investigation, profiling community immunity, and systematic search of health facilities (private & public) for any SL2 isolates and responding to new VDPVs in line with global guidelines and as advised by the Advisory Group on use of mOPV2.

**Risks in Southern States:** ERC notes the appropriate focus of the programme activities in the northern States where the risk of polio transmission is highest. However, it notes the need to continue to ensure high population immunity in the Southern States to protect against the risk of the spread of the virus to the South. ERC urges the programme to ensure the conduct of high quality NIDs and maintain and strengthen sensitive surveillance system.

**Routine Immunization:** ERC notes the reported mismatch between administrative and validated coverage data. The ERC observes that the reported measles outbreaks and NNT cases are indicative of population immunity gaps due to low routine immunization coverage. Consequently, ERC reiterates its recommendations on EPI strengthening at its 32<sup>nd</sup> meeting held in June 2016.

**Transition planning:** ERC acknowledges that the timeline for the country transition planning process has been affected by the reclassification of Nigeria as a polio endemic country by WHO in September 2016 following the resurgence of WPV1 after 2years of zero polio case. ERC urges government to take leadership in leveraging resources for RI, PHC, disease surveillance and outbreak response and other public health priorities.

## Introduction

The 33<sup>rd</sup> Expert Review Committee (ERC) for Polio Eradication and Routine Immunization (RI) was convened on 17-18 January 2017 in Abuja. The ERC expresses concern at the outbreak of four cases of Wild Polio Virus (WPV1), after two years without a case and a case of circulating vaccine derived poliovirus (cVDPV2), between July and October 2016. The ERC declared that it was an error for the programme to believe that it had achieved WPV interruption in 2015, when some parts of the country were inaccessible due to insurgency. It added that the WPV1 outbreak should serve as a lesson to all stakeholders as no one can confidently predict when the country will be polio free if some areas remain inaccessible.

However, the ERC acknowledges and commends the country for the timely, robust and quality response to the outbreaks and urged the programme to continue to do what needs to be done to ensure that every eligible child is reached.

This report summarizes the main findings, conclusions and recommendations of the 33<sup>rd</sup> meeting of the ERC.

### Current epidemiological situation

As at 31 December, 2016, four cases of wild polio virus type 1 (WPV1) were reported in three LGAs in Borno State. Also, within the same period, two cases of circulating Vaccine Derived Poliovirus (cVDPV2) were reported in Borno and Sokoto states. The former is an environmental isolate from sewage collected in March 2016. A healthy contact of WPV (with onset in August 2016) case in Borno State (Monguno LGA) was positive for cVDPV2.

### Report on the 32<sup>nd</sup> ERC Recommendations

The ERC reviewed the report on the status of implementation of the 32<sup>nd</sup> ERC recommendations and commends the national programme for implementing the key recommendations in spite of the WPV1 Outbreak. ERC commends the Federal Government for releasing the needed fund for the outbreak. However, it notes the waning political support as evidenced by suboptimal attendance of chairmen at evening review meetings and the failure of the Presidential Task Force on Polio Eradication (PTFoPE) to meet since the inception of the current Government. The ERC therefore reiterates its recommendation at the 32<sup>nd</sup> ERC meeting that the PTFoPE should be convened urgently. Government may wish to consider (if it has not done so already) to saddle a high ranking government official, (possibly at the level of the Minister of State) with organization and coordination of the functions and activities of the PTFoPE. The ERC calls on government and donors to sustain funding of PEI activities in 2017 and beyond.

Since the last ERC meeting, the country experienced a resurgence of WPV1 between July and October 2016 and has successfully conducted five timely, robust and quality outbreak response campaigns between August and December 2016 in response to the WPV1 outbreak and two mOPV2 rounds in response to cVDPV2. The first round of OBR was held in five States categorized as Zone 1 (Borno, Yobe, Adamawa, Gombe and Taraba) from the 27th to 30th August 2016, using bOPV. The second round was held in zone 1 and zone 2, comprising 18 States (Bauchi, Kano, Kaduna, Katsina, Kebbi, Jigawa, Sokoto, Zamfara, Niger, Nasarawa,

Benue, Plateau, Federal Capital Territory [FCT]) States from 17th to 20th September 2016, using bOPV. In Borno State bOPV was integrated with IPV to rapidly boost the population immunity. The third, fourth and fifth responses were in the same 18 States from 15th to 18th October 2016, 12th to 15th November 2016 and 3rd to 6th December 2016 respectively.

In response to the outbreak of a cVDPV2 case in Sokoto State in October 2016 and the isolation of cVDPV2 from the healthy community contact, an immediate response round involving the affected Bodinga LGA and two Wards of neighbouring Shagari LGA were conducted 3-6 December, using mOPV2 vaccine. A large scale second round involving the six northeast States and Sokoto State was conducted from 16 to 19 December 2016 in synchronization with the Lake Chad Basin countries. The third mOPV2 OBR round is scheduled for 28 to 31 January 2017 in 18 States.

Several innovations were deployed during the outbreak response campaigns. These include settlement based accessibility assessment, systematic engagement of Civilian Joint Task Force (CJTF) & the Military as rapid access vaccination teams, deployment of health camps to underserved and non-compliant population, vaccination of IDPs, placement of transit teams at strategic locations and directly observed polio vaccination using attractive pluses.

The resilience strategy is being sustained through intensified high level advocacy to increase political commitment and oversight, intensified social & community mobilization through a range of stakeholders, building trust by addressing community felt needs, using health camps, customized pluses, and promotion of integrated services and motivational awards. Motivational interpersonal communication (IPC) skill training was launched in Borno State, using the integrated package. Over 4000 frontline workers were trained. In-between rounds, over 17000 VCMs have continued to track and vaccinate missed children and conduct active AFP case search in households and IDPs camps. Also, 1681 Federation of Muslim Women Associations in Nigeria (FOMWAN) mobilizers, 1386 polio survivors, 220 religious focal persons and community leaders are engaged in community mobilization during and in-between rounds. The religious focal persons are facilitating access to over 17,000 local religious leaders and Quranic school teachers.

The programme has continued to track political commitment using the IPDS dashboard as well tracking and reporting quarterly on Abuja commitment indicators. Political commitment is suboptimal at State and LGA levels as evidenced by the inadequate and late release of counterpart funds and poor performance of LGA Chairmen in chairing evening review meetings (ERMs). In most of the States during the five rounds of OBR, less than 50% of ERMs were attended by LGA chairmen.

In security challenged areas of Borno, Volunteer Community Mobilizer (VCM) network was expanded from 13 to 23 LGAs especially in recently accessible areas, including Dikwa, Kukawa, Mungono, Bama and Nganze LGAs. VCMs conduct mobilization activities at IDPs in formal & informal camps and IDPs in host communities. Also, VCMs are conducting active case search for AFP in IDPs & host communities. A total of 397 VCMs were trained on AFP

and priority disease reporting. Sensitization of traditional & religious leaders, women and caregivers in both accessible & newly accessible settlements including Gwoza, Dambao and Nganzai LGAs is on-going. Tsangaya School Malams and RFPs were trained on IPC skills. The outcome of all these interventions is that non-compliance reduced from 1% in Oct. OBR to 0.2% in December OBR.

Poliovirus laboratory containment (Phase 1b) activities were conducted between September and October 2016 with the aim of locating and destroying type 2 poliovirus isolates (wild and (Sabin/VDPV2, and other poliovirus infectious and potentially infectious materials) available in the laboratories and Sabin/VDPV2 that may be available in immunization sites, industries etc. . Out of the 560 biomedical facilities surveyed, 12 biomedical facilities in nine states were found to contain poliovirus and poliovirus potentially infectious materials including stool specimens, rectal swabs, CSF and waste water. Eight health facilities from seven states had vaccine vials (tOPV/mOPV2) which were destroyed. The report of phase 1b containment for the country was submitted timely to WHO AFRO on 31st October 2016.

Some initiatives were introduced to ensure timely delivery of vaccines and other logistics as well as ensure vaccine accountability. These include cross-docking directly to states, submission of vaccine availability report (VAR) within 24 hours of vaccine arrival, deployment of national logisticians to implementing states, training of 43 Vaccine Security And Logistics Consultants (VSLCs) at the national level on guidelines for management of mOPV2 which was cascaded to relevant stakeholders (Local Immunization Officers (LIOs), Local Cold Chain Officers (LCCOs), Ward Focal Persons (WFPs), Director Primary Health Care [PHC]), revised data tools and introduced Form A, documentation of all vials collected by senior supervisors/VCMs and counting as well as packing of all empty vials each day. These initiatives resulted in reduced wastage rates, improved documentation of utilization of OPV (Over 90% of teams record vials received), improved documentation of OPV at storage sites and improved vaccine accountability at all levels.

However, challenges were encountered in security-compromised areas including: distribution and retrieval being hinged on availability of security personnel, inadequate storage facilities at lower levels especially ward level, inadequate ice packs production, poor communication and challenges with report collection (information on vaccine supply adequacy and utilization not readily available), requirement of helicopter and armoured vehicles in some areas. Key activities to address the challenges include collaboration with military in distribution and retrieval of vaccines and related information, procurement and deployment of Solar Direct Drives refrigeration systems and collaboration with World Food Programme for airlift of supplies to security challenged areas.

Following the recent WHO reclassification of Nigeria as a polio endemic state, the country is no longer expected to meet the time frame of December 2016 for completion of its transition planning. However, transition planning process is ongoing with focus on the identified three key areas for transitioning polio infrastructure - PHC revitalization, Expanded Programme on Immunization (EPI) /routine immunization (RI) and disease surveillance and

outbreak response. The finalization of the country's transition plan has been scheduled for June 2017.

Inactivated Polio vaccine (IPV) and Pneumococcal Conjugate Vaccine (PCV) has been introduced into RI nationwide. Although there are improvements in RI coverage, as cohort of unimmunized children reduced from 718,116 in 2015 to 618,167 in 2016, however, 11 States had an increased cohort of unimmunized children within the same period (Anambra, Bayelsa, Edo, Ekiti, Enugu, FCT, Katsina, Kogi, Oyo, Sokoto and Zamfara).

There is a mismatch between reported administrative coverage and findings on community and field investigations as evidenced by discrepancies in the data from District Vaccine and Devices Monitoring Tool (DVD-MT), District Health Information System<sup>2</sup> (DHIS2), Routine Immunization Supportive Supervision (RISS) and survey coverage. Almost 80% of Measles outbreak and significant proportion of Neonatal Tetanus (NNT) reported are from the Northern part of the country, indicating pockets of low routine immunization. Measles control program is conducting an outbreak Response Vaccination in two phases between 12 and 23 January 2017, in 46 LGAs in three Northeast States - Adamawa (5 LGAs), Borno 25 LGAs; and Yobe (6 LGAs) targeting 4,766,215 children, with an expanded target age of 6 months to ten years. Yellow Fever campaign was held in 3 States (Osun, Oyo & Ogun) in 2016 while Maternal and Neonatal Tetanus Elimination (MNTE) preventive campaigns were held in March and September 2016 in 61 high risk LGAs in 6 states (Ebonyi, Enugu, Imo, Osun, Ondo, Ekiti). Coverage survey was conducted in the LGAs in October 2016.

The programme has sustained high quality campaigns during the five rounds of OBR. All LGAs surveyed achieved the global benchmark of at least 80% coverage in all 18 States in all the five rounds. However, when the programme raised the benchmark to 80% of LGAs achieving at least 90% coverage, 71% and 77% of LGAs surveyed during the second and third OBR rounds respectively, achieved at least 90% coverage.

Inaccessibility in security compromised States remains the greatest challenge to the polio programme in Nigeria. Other challenges include highly mobile high risk populations such as IDPs, nomads, waning political commitment and support from governors and LGA chairmen, surveillance gaps and data quality, global vaccine shortage and funding gap.

## Programme Developments

The ERC notes the following key developments since the last meeting:

- Resurgence of WPV in Nigeria after 2 years of stopping transmission - 4 cases of WPV between July and August 2016 from IDP families
- cVDPV2 from the environment & 1 healthy contact in 2016 and one cVDPV2 case in Sokoto
- Five Swift and high quality outbreak response campaigns conducted using bOPV & IPV (Borno State)
- mOPV2 rounds conducted in response to cVDPV2 outbreak post-tOPV-bOPV switch
- Lake Chad countries outbreak Response Activities Review and Coordination Assessment in November 2016
- Introduction of Settlement-based accessibility mapping in Borno and Yobe States
- Systematic engagement of CJTF with military escort as Rapid Access Vaccination teams
- Target age for OPV vaccination in Borno State extended to 10 years for IDPs and recently liberated areas
- Sustained high quality of campaigns with over 80% LQAs trend in OBR campaigns
- Two external surveillance reviews conducted in August and November 2016.
- Verification of AFP cases within 7 days. 89% of AFP cases verified in 2016
- Introduction of temperature tracking to record temperature of specimen from point of collection every five minutes to when the specimen reaches the lab.
- 75 polio personnel received Rotary Performance Award for excellence for the year 2016
- Monitoring and review of VCMs performance through the settlement level register and tracked vaccination status of all eligible children and enforcement of accountability framework
- 397 VCMs in from Borno trained on AFP and priority disease reporting
- VCMs mobilizing and conducting active AFP case search in formal & informal IDPs camps & IDPs in host communities
- Sustained systematic post campaign tracking and vaccination of all missed children during in-between round activities by VCMs
- VCM network expanded from 13 to 23 LGAs (Recently Accessible LGAs/settlements)
- Recruitment of new VCMs in Dikwa, Kukawa, Mungono, Bama and Nganze LGAs of Borno State.
- Sustained strong political leadership & support at the national level, including GPEI partners
- Reactivation of High Level Advocacy Team (HILAT) - Advocacy intervention jump-started in NEZ
- Sub-optimal political support and commitment at State & LGA levels

- Conduct of Phase 1b containment - 12 biomedical facilities in 9 states were found to contain poliovirus and poliovirus potentially infectious materials and 8 health facilities from 7 states had vaccine vials (tOPV/mOPV2) and all these were later destroyed.
- LIDs conducted in 7 States with high cohort of un-immunized children – Akwa Ibom, Bayelsa, Benue, Edo, Enugu, and Lagos & Ogun.
- New Micro planning introduced in Borno, Yobe & Benue leading to an improved workload rationalization & team performance.
- Use of IPV during Sept 16 OBR in Borno reaching a total 1,526,947 and 314,392 in Yobe (4 LGAs).
- Focused Vaccinations in Transit points, Market, Nomadic & IDP camps to capture populations from inaccessible settlements during OBRs.
- Use of Mock LQAs to improve OBRs in Borno State
- Scale up of use of DOPV in 12 additional LGAs for OBR in Borno (7 LGAs), Yobe (4 LGAs) & Sokoto (1 LGA)
- Triangulation of information from data sources to further assess quality of SIAs:
  - Compare LQAs and IM data for discordance (>10% difference)
  - LQAs verification
  - Further investigation of LGAs with discordant results for corrective action (OM Vs. LQAS, LQAS Vs. Verification)
  - Identify and verify missed settlements (VTS) and take appropriate actions
- Monitoring of independent monitors
- PHC revitalization programme launched on 10 January 2017 by Mr. President
- NPHCDA setup National PHC revitalization initiative secretariat
- Country experiencing economic recession

## Key Risks

The ERC however, identified major risks to stopping poliovirus transmission in Nigeria, as follows:

1. Failure of Presidential Task Force to meet
2. Insecurity and inaccessibility
3. Surveillance gaps and data quality
4. High risk populations; IPDs, nomads and mobile populations
5. Waning political commitment, resulting in and non-release of counterpart Funding, especially at State and LGA levels in some high-risk states
6. Global vaccine availability risk
7. Funding Gaps.

1. **Failure of the Presidential Task Force on Polio Eradication (PTFoPE) to meet:** ERC commends the Federal Government for the release of ₦9.8b following the WPV1 outbreak. However, ERC is concerned that the Presidential Task Force on Polio Eradication (PTFoPE) has not met in the last two years, particularly since the inception of the current Government. ERC concludes that this is a major contributory factor to the waning political support being experienced at the State and LGA levels. This has resulted in suboptimal and late release of counterpart funds by some States and LGAs and poor attendance of ERMs by some LGA chairmen with the potential to hinder effective implementation of planned activities.
2. **Insecurity and inaccessibility:** ERC recognizes the fact that the programme has continued to make concerted efforts to boost the immunity of children in security challenged States of the North East and appreciates the various strategies to reach children, particularly from recently accessible areas, such as Reaching Every Settlement (RES) strategy. However, detection of orphan viruses in Borno State reflects presence of sizeable missed population in the conflict affected areas with limited reach of surveillance network. While the presence of WPV1 and cVDPV2 pose risk of continued transmission and spread to neighbouring States and countries. Also, estimating population living or trapped in the inaccessible areas remains a challenge, noting that malnourished children among IDPs may have different immunological response to vaccination. ERC notes that significant risks of poliovirus transmission remain, occasioned by the complete inaccessibility to children in 58% of settlements in Borno State and 7% in Yobe State and the fluid levels of accessibility across other states in the North East.
3. **Surveillance Gaps and data quality:** ERC is concerned about report of missing AFP cases due to poor quality surveillance and the report of higher AFP surveillance indices in inaccessible areas compared with the accessible areas of Borno and Yobe states. The ERC concludes that the discrepancy could be due to surveillance gaps and/or the quality of data. Consequently, ERC aligns with the conclusion of the follow-up External Surveillance Review in Borno State, that the 'likelihood of missing transmission, particularly in internally displaced persons and inaccessible population cannot be ruled out' and that 'gaps persist in quality of active surveillance and in IDPs camps'.



4. **High risk Populations; IDPs, nomads and mobile populations:** ERC notes the presence of high risk populations, including IDPs, nomads and mobile populations across the country and concludes that they pose a risk as there is the likelihood of missing poliovirus transmission in Borno, parts of Yobe and Adamawa States due to inaccessibility and surveillance gaps. Also, the reporting of polio compatible cases from Kaduna and Kano States reflects sub-state level surveillance gaps.
5. **Waning political support from Governors and LGA Chairmen in some high-risk states and release of counterpart funding:** ERC notes the waning political commitment and support at all levels particularly the inability of the Presidential Task Force on Polio and Routine Immunization (PTFoPE) to convene for two years, the suboptimal engagement of Governors and LGA Chairmen and the suboptimal and late release of counterpart funding by some States and LGAs. ERC concludes that this state of affairs will impact negatively on the quality of implementation of planned interventions and result in reversal of current achievements and gains.
6. **Global vaccine availability risks:** The ERC acknowledges the challenges with vaccine availability globally and the support by the global community by prioritizing Nigeria in vaccine allocation. It is imperative that Nigeria puts in place a formidable vaccine accountability mechanism, while the global community sustains the prioritization of the country in vaccine allocation to ensure all planned SIAs are implemented as scheduled.
7. **Funding Gaps:** ERC commends the Federal Government of Nigeria and partners for the release of all funding requirements for 2016, in particular the release of 9.8billion by the FGN following the outbreak of WPV1 in August 2016. However, ERC is concerned about the funding gap of \$475.5m for 2017-2019, out of which \$73million is for 2017, the anticipated drop in GPEI financial resources from 2017 and the frequent health worker unrests across the states due to delayed payment of salaries and allowances. The ERC notes that timely release of financial resources by government and donors is critical for quality implementation of planned SIAs aimed at stopping transmission of WPV and cVDPV and maintaining population immunity in other parts of the country.

## Conclusion and Recommendations

The ERC after careful consideration of presented epidemiological situation and programme data, developed conclusions and formulated recommendations on actions needed to sustain the efforts to interrupt transmission in the North East and maintain population immunity in the rest of the country.

### Conclusion

The ERC commends the rapid, aggressive and unprecedented outbreak response with frequent short interval SIAs, managing different antigens and quality under very complex circumstances after maintaining zero polio case status for 23 months, particularly the initiatives taken to increase access in partially and completely inaccessible areas, including: ① Systematic engagement of the military and CJTF, ② Deployment of health camps targeted to underserved and non-compliant population, ③ Targeted vaccination for IDPS, ④ Transit vaccination teams placed at strategic locations and ⑤ Directly Observed OPV (DOPV) administration with *Pluses* in select areas.

The ERC attributed this achievement to the extraordinary efforts and commitment of Government of Nigeria and partner agency staff in responding to the recent WPV1 and cVDPV2 outbreaks.

However, the ERC is concerned with reports in July 2016, after an interval of almost 2 years, of new WPV1 cases genetically linked to polioviruses that were circulating in Borno in 2011. This is an evidence of prolonged undetected indigenous polio transmission. It therefore concludes that the WPV1 outbreak is a setback for the country and that there is need to reach children in inaccessible areas to save Nigeria from being an embarrassment to the rest of the world.

### Recommendations

#### 1. Estimation of population living or trapped in the inaccessible areas

The ERC notes that inaccessibility in Borno remains a challenge to the Nigeria PEI Programme as almost 50% of the settlements did not report an AFP case during 2016 indicating limited reach of surveillance network in the inaccessible areas. Also, during the SIAs held in 2016, between 39% and 52% of the settlements were inaccessible.

The ERC therefore recommends that the Programme should:

- Continue the recent initiatives on gaining access, particularly Reaching Every Settlement (RES) Strategy in close coordination with the security forces
- Adopt using satellite imagery and VTS to estimate the inaccessible population (Estimated population ranges 0.4-0.6m)
- Maintain an in-depth analysis of the data on vaccination for newly arrived population, permanent transit teams, RES is important to monitor the evolving situation on the inaccessible children

## **2. Enhance surveillance in the inaccessible areas, IDPs and other high-risk populations**

ERC notes that high risk populations pose a key risk to the programme as polio transmission among them is likely to be missed due to surveillance gaps and inaccessibility.

ERC therefore recommends that the programme should;

- Ensure implementation of recommendations of the recent external surveillance reviews with focus on IDPs, Partially/inaccessible areas
- Intensify recent initiative on quality of active surveillance, systematic training of community informants, AVADAR (e-reporting of AFP cases), e-Serve (tracking of DSNOs), and engagement of medical corps of security forces
- Conduct stool examination on samples of healthy children arriving from the inaccessible areas
- Conduct additional sewage sampling like “sweep” on adhoc basis across the security compromised LGAs
- Investigate all polio compatible cases to understand reason for delay in reporting and take corrective actions
- Increase efforts to ensure AFP surveillance network reaches the nomadic population

## **3. Internally Displaced Population**

ERC notes that the displacement of highly susceptible populations from different inaccessible LGAs following Military successes continues with formation of formal and informal camps and adds that while IDPs pose a challenge, the camps offer a unique opportunity to build their immunity and conduct active surveillance.

ERC therefore recommends that the programme should:

- Map all settlements and track movement of IDPs
- Ensure high quality active surveillance and SIAs in formal and informal camps
- Monitor progress through regular data analysis

## **4. Advocacy and Communication**

The ERC is concerned about the waning political commitment at various levels particularly noting the inability of the Presidential Task Force on Polio Eradication and Routine Immunization (PTFoPE), to meet for the past 2 years as well as the late and sub optimal release of counterpart funding by some states and LGAs and attendance of evening review meetings by LGA Chairmen.

The ERC recommends that:

- PTFoPE meeting should be held urgently
- The Minister of Health may wish to consider (if not already done) saddling a high ranking government official, (at the level of the Minister of State), with the coordination of the function and activities of the PTFoPE
- Programme should sustain and intensify the resilience strategy through community engagement and contextualized messaging in the NE using all social networks such as VCM, NTLC, social mobilization committees

- Programme should develop innovative strategies to increase political support at State and LGA levels and increase active participation of LGA Chairmen in Polio activities including attendance at evening review meetings.
- Programme should ensure all missed children are systematically tracked by VCM network and use of its full potential to vaccinate, using every opportunity during and in between polio campaigns.
- Programme should expand VCM network to Gombe, Adamawa and Taraba states to address missed children and ensure full community engagement to reduce noncompliance and child absent

## **5. Funding Gap 2017-2019**

ERC acknowledges the prompt release of ₦9.8billion by the Government of Nigeria in response to the WPV1 outbreak. However ERC is concerned about the funding gap of \$475.5m for 2017-2019 and the planned ramping down of GPEI financial resources from 2017. ERC notes that the timely release of all financial resources is critical to stopping polio transmission and maintaining population immunity across the country. ERC therefore recommends:

- Advocacy with Government to fulfil contribution for 2017 as per FRR (N9.8billion) including timely procurement of vaccines for 2017.
- Partners to release funds timely in accordance with FRR

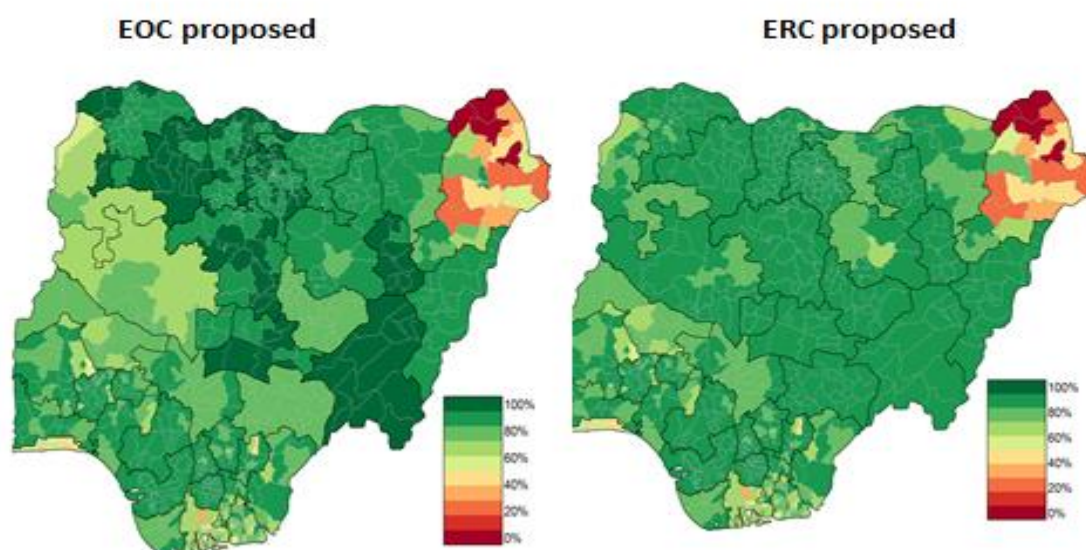
## **6. Supplemental Immunization Activities (SIAs) Calendar 2017**

The ERC notes the need to strike a balance between the number of SIAs and the quality of campaigns taking into consideration the fact that the country is in economic recession and global vaccine availability risks and urges the program to focus on Stopping transmission of WPV1 and cVDPV2, and maintaining population immunity in rest of the country. Consequently, the ERC reviewed the proposed 2017 SIAs calendar of 2 NIPDs and 5 SIPDs and recommended 2 NIPDs, 4 SIPDs in high risk States, using bOPV and expanded the scope of the SIPDs to 18 States as against 14 States proposed, except the February round which is for 14 States. It urges the programme to complement the SIAs with in-between round interventions. ERC observed that there is no significant difference between the estimated population immunity by December 2017 that will be conferred by the EOC proposed calendar and the ERC recommended calendar.

## SIA Calendar 2017: Focus to Stop WPV1 and cVDPV2, Maintain population immunity in rest of the country

S/N	Month	Dates	Scope	Remarks	Target Populations	Antigen
	January	28 <sup>th</sup> - 31 <sup>st</sup>	SIPDs (18 States)	2nd mOPV2 OBR in 18 states	33,478,035	mOPV2
1	February	25 <sup>th</sup> - 28 <sup>th</sup>	SIPDs (14 High Risk States)	List of high risk states reviewed using the HR Algorithm and local information on risk	26,256,251	bOPV
2	March	25 <sup>th</sup> - 28 <sup>th</sup>	NIPDs (36+1)	Nationwide	59,961,520	bOPV
3	April	22 <sup>nd</sup> - 25 <sup>th</sup>	NIPDs (36+1)	Nationwide	59,961,520	bOPV
4	July	1 <sup>st</sup> - 4 <sup>th</sup>	SIPDs (18 High Risk States)	High Risk States	33,478,035	bOPV
5	October	14 <sup>th</sup> - 17 <sup>th</sup>	SIPDs (18 High Risk States)	High Risk States	33,478,035	bOPV
6	December	9 <sup>th</sup> - 12 <sup>th</sup>	SIPDs (6 High Risk States)	High Risk States	8,285,075	bOPV

### Estimated Population Immunity by Dec 2017: EOC Proposed IPDs calendar versus ERC Proposed Calendar



## 7. Vaccine Management

ERC acknowledges interventions instituted to improve vaccine management but notes that gaps still exist especially at state and LGA levels in terms of vaccine security and accountability and capacity.

ERC therefore recommends that the programme should:

- Strengthen vaccine supply management and ensure existing stocks are factored into any new vaccine requests.
- Comply with the guidance note, SOPs and tools for data capture that have been designed by the GPEI and shared for implementation.

- Ensure the return of unused vaccines and the disposal of the mOPV2 to maintain zero balance of mOPV2 after the planned January SNID as per global guidelines.

#### **8. Emerging risk of VDPV2 and Sabin like type 2(SL2)**

The ERC is deeply concerned about the risk of Sabin Like type 2(SL2) isolates particularly as the country has successfully switched from tOPV to bOPV since April 2016 and noted that isolation of VDPV2 and SL2 are indicators of possible population immunity gaps and on-going use of type 2 containing vaccines. ERC urges the programme to address the emerging risk of VDPV2 and SL2 as the latter isolates are reportable under International health Regulations (IHR).

The ERC therefore recommends that the programme should:

- Conduct thorough investigation, profiling community immunity for any SL2 isolates and systematic search of health facilities (private & public) for tOPV
- Respond to new VDPVs in line with global guidelines and as advised by Advisory Group on use of mOPV2

#### **9. Addressing the risks in Southern states**

ERC acknowledges that the programme is appropriately focusing on the northern States where the risk of polio transmission is highest. However, it notes the need to continue to ensure high population immunity in the Southern States to protect against the risk of the spread of the virus to the South.

ERC therefore recommends that the programme should:

- Ensure the conduct of high quality NIDs
- Maintain and strengthen sensitive surveillance system all over the country
- Strengthen Routine immunization-using IPV and bOPV all over the country

#### **10. Routine Immunization**

**Routine Immunization:** ERC notes the reported mismatch between administrative and validated coverage data. The ERC observes that the reported measles outbreaks and NNT cases are indicative of population immunity gaps due to low routine immunization coverage. Consequently, ERC reiterates its recommendations on EPI strengthening as its 32<sup>nd</sup> meeting held in June 2016.

ERC therefore recommends that the EPI team should:

- Implement the 32<sup>nd</sup> ERC meeting recommendations held in June 2016, to strengthen Routine immunization.

#### **11. Transition planning**

ERC acknowledges that the timeline for the country transition planning process has been affected by the reclassification of Nigeria as a polio endemic country by WHO in September 2016 following the resurgence of WPV1 after 2 years of zero polio case.

ERC therefore recommends that:

- The presented timeframe for implementation of transition planning be implemented
- Government should take leadership in leveraging resources for routine immunization, PHC revitalization, Disease surveillance and outbreak response and other public health priorities

### Next ERC Meeting

After consultations with the Programme, the ERC chairman will propose a date for next meeting in late May or early June 2017 for members' consideration.