19th Meeting of the Expert Review Committee (ERC) On Polio Eradication & Routine Immunization in Nigeria

Minna, Nigeria

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Executive Summary

The ERC believes that significant progress is being made in eradicating polio from Nigeria. The progress is seen in the dramatic reduction of transmission of polioviruses in the second half of 2009, and has been achieved primarily through improvements in immunization coverage of children during IPDs. These improvements in coverage have in turn been made possible by the deepening engagement of political and traditional leaders in polio eradication in Nigeria.

The ERC continues to believe that polio can be eradicated from Nigeria in 2010, if the commitment of political, government, and traditional leaders is sustained and strengthened, if the improvements in the quality of IPDs are sustained and expanded, if an aggressive schedule of IPDs is maintained, and if there is appropriate use of all types of OPV. **However the ERC warns strongly against any diminution of effort at this critical stage of eradication. There remain significant risks to polio eradication in Nigeria, including low routine immunization coverage, which must be addressed before Nigeria will be polio-free.**

Major Recommendations:

1. *High risk Local Government Areas:* 85 LGAs are at significantly elevated risk of sustaining wild poliovirus transmission; they are the most consistently infected LGAs in the country, they have much worse immunization indicators than the average LGA (47 of these LGAs are in the 4 very high priority states of Kano, Zamfara, Katsina, and Borno). These LGAs require specific plans and specific actions to ensure that all children are reached with vaccine. The implementation of the HR LGA plans should be closely monitored at LGA level, State level, and Federal level before and following each IPD round.

2. *Government oversight and commitment:* the ERC urges the Federal Government and State Governments to continue to take a leadership role on polio eradication. State Governors are urged to hold to the Abuja Commitments, to report back to the President on a quarterly basis including tracking of indicators, and to make every effort to ensure the engagement and accountability of Local Government authorities.

3. *Engagement of traditional leaders:* the national programme and partners should continue to fully engage traditional leaders in polio eradication activities, given the clear impact that their engagement has had on improving access to children. This engagement is particularly critical in the 85 high risk LGAs, to ensure that ward and village heads actively participate. ERC requests Traditional Leaders to ensure 100% of Ward and Village Heads play a supervisory role in upcoming IPDs in HR/VHR LGAs and track this closely.

4. *IPD Schedule & Choice of Vaccine:* the ERC recommends that sub-national IPD rounds be carried out in April, June, September, and October using bOPV if available, and mOPV if it is not; the choice of mOPV will depend on the epidemiology. A further round should be carried out in November using tOPV in conjunction with Child Health Days.

5. *Mopping up in response to poliovirus:* effective immediately, any WPV1, WPV3, or cVDPV case in any state should be responded to by an appropriate and rapid mop-up with type specific vaccine as per global recommendations.

6. *Enhancing IPD Quality & Coverage:* As a standard response, in any ward where monitors find more than 10% missed children following an IPD round the activity should be repeated. LQAS should be used to provide additional information on quality in high risk LGAs.

7. *Community Mobilization:* Communication and social mobilization activities and objectives should be integrated into specific HR/VHR LGA plans and updated and implemented for every SIA based upon trend analysis of campaign indicators and other forms of social data

8. *National Planning:* the Government should continue to maintain a rolling 12 month planning timeframe for the intensified effort that is needed to finally stop transmission of WPV.

Introduction:

The 19th Expert Review Committee for Polio Eradication and Routine Immunization was convened from 22-24 March 2010 in Niger State. The previous meeting was in September 2009.

The ERC was welcomed by the Executive Director of the NPHCDA, who posed key questions to the committee:

- What is the population immunity threshold required to stop WPV in Nigeria and what additional strategies or activities should be implemented to achieve the population immunity threshold required to interrupt wild poliovirus circulation?
- What is the optimal SIA schedule and selection of vaccine formulations to ensure the interruption of WPV and cVDPV? Could there be considerations for reducing the number of SIAs in the second half of 2010 in return for better quality rounds?
- What is the role of LQAS in providing additional monitoring data? How frequently should these be performed and how wide?
- How can recent gains in quality achieved in IPDs be rapidly applied to improve routine immunization coverage?
- What are the key research questions that need to be pursued by Nigeria at this point in time?
- What is the ERCs self-evaluation at this stage of the programme?

The ERC was very pleased to have representatives of all states participate fully in the meeting. Representatives of key partner agencies also attended, including the four global spearheading partners (WHO, Rotary, UNICEF, CDC).

This report summarizes the main findings, conclusions and recommendations of the 19th meeting of the ERC.

Report on the 18th ERC Recommendations:

The ERC noted the report on the status of implementation of the 18th ERC recommendations, and congratulated the national programme and partners on their efforts. Progress has been achieved against several recommendations, including improvements in the immunization status of children in endemic states, and in continuing the engagement of political and traditional leadership. However, although the ERC believes that the previous 6 months have seen a sustained effort to address programme shortcomings, certain elements of the recommendations have not been appropriately addressed. The ERC would have appreciated some more concrete information on several recommendations, including for example the repeating of activities in wards with more than 10% missed children during SIAs, and more specifics on the efforts targeted to high risk LGAs to improve performance.

Report on the Abuja Commitments

The ERC received a report on the progress in achieving the Abuja Commitments made by all the State Governors of Nigeria in February 2009. Nearly half of all states now have functioning EPI/PEI coordination committees, and in some states there has been solid progress in forming LGA task forces. The most substantial compliance with the commitments is in the endemic states. The ERC welcomes this progress but notes that there are still significant gaps against the indicators, particularly with

respect to engagement of LGAs, and particularly the continued relative lack of compliance with commitments in non-endemic states.

Report on the engagement of traditional leaders

A report on the work of traditional leaders and their impact on accessing children was provided by HRH Emir of Argungu. The ERC is impressed by the scope and impact of the engagement of traditional leaders and believes that this offers benefits not just for polio eradication, but for immunization in general and other public health interventions. This has been a major programme development over the last 12 months with clear implications for improving access, accountability, and compliance. However, further scaling up of these efforts is needed in several States and especially in the high risk LGAs.

Current epidemiological situation:

As at 19 March 2010, a total of 388 WPV cases with onset in 2009 had been reported in Nigeria, 75 due to WPV1 and 313 due to WPV3, in twenty-seven states. Only one case has so far been reported in 2010, due to WPV3, in Delta state with onset in January. Surveillance data is complete up to the end of January 2010 and for much of February, therefore the ERC was able to consider the full period from the previous meeting through to the end of January 2010 in assessing developments.

The most significant epidemiological development since the last meeting of the ERC has been the dramatic decline in transmission of all polioviruses in the second half of 2009. Over the 6 month period from August 2009 to the end of January 2010, there have been only 13 cases of polio due to wild poliovirus reported in Nigeria. Of these cases, 11 were due to WPV3 and only 2 due to WPV1. This is the lowest transmission over a six month period that has been recorded in Nigeria since reliable surveillance began. The very low level of transmission of WPV1 is of particular note. **In the previously most endemic states, Kano, Katsina, and Jigawa, no WPV1 has been reported now for 12 months.** No WPV1 has been reported from the re-infected southern states for 6 months.

WPV3 transmission also dropped very rapidly from the second quarter of 2009 onwards, following the use of mOPV3 and tOPV in IPDs in the second and third quarters. In the first two quarters of the year 290 WPV3 cases were reported; by the third quarter only 17 cases were reported, dropping to 7 in the last quarter.

Transmission of cVDPV type 2 has also declined significantly following the use of tOPV in IPDs in May and in August 2009. In the third quarter of 2009 9 cases were reported, down from 84 in the second quarter; and by the fourth quarter only 5 cases were reported. A single case has been reported in 2010 in Kano with onset on 17 February. Trivalent OPV was used throughout the country in March 2010.

Programme developments

The ERC noted the following developments since their last meeting:

- **Continued efforts to engage political leaders and improve accountability.** The Executive Director reported on the monitoring of the Abuja Commitments, as noted above, demonstrating that this framework for monitoring commitment and accountability is still being actively used.
- **The effective work of traditional and religious leaders.** In northern states very significant progress has been made with the engagement of traditional leaders and the mobilization of their networks, to ensure that all children are reached.
- **The evidence of more children being reached with immunization during IPDs.** Monitoring data from IPD rounds through 2009 and early 2010 have shown a consistent reduction in the proportion of wards failing to achieve 90% coverage, from 26% in the January 2009 IPD to 11% in the most recent IPD in March 2010.
- **The continued improvement of immunization status of children.** In the first quarter of 2010, for the first time ever, the proportion of children in endemic states with 3 or more doses of OPV has risen to over 80%.
- **Improvements in the consistency of surveillance.** Although gaps in surveillance remain, the consistency of AFP surveillance has improved over the last 12 months, and an impressive programme of peer reviews has reduced the number of LGAs not meeting both surveillance indicators from 22% in 2008 to 14% in 2009.

Risks

The ERC feels that while there is now a great opportunity to finish polio in Nigeria, there remain very significant risks for continuation of transmission, or for re-establishment in non-endemic areas. These risks are:

- **The potential to lose political leadership and focus in the lead up to the 2011 elections.** Already there are signs of a loss of momentum in some states; the report on the Abuja Commitments notes the failure of several states to comply, and a lack of engagement particularly at LGA level. Given the importance of political engagement to the gains made in 2009 this is a potentially very serious problem.
- **The failure of some LGAs in endemic states to reach all children with vaccine.** Analysis of epidemiological data, immunization status data, and IPD monitoring data identifies **85 LGAs in endemic states at high risk of continued WPV and cVDPV transmission**. These LGAs have not succeeded in adequately improving immunization coverage of children in IPDs or through routine immunization and have a much worse immunization profile than other LGAs. On average in these high risk LGAs more than 30% of monitored wards achieve an IPD coverage of less than 90%, which is nearly three times the rate of non-high risk LGAs. **Unless immunization status is improved, these LGAs will retain the capacity to sustain transmission of WPV and re-introduce it into the general population.**
- **Inadequate routine immunization coverage in nearly all states**, but particularly in non-endemic states that depend on routine coverage to sustain high levels of population immunity. The 2008 - 2009 outbreaks in non-endemic states demonstrated that population immunity levels in general have been inadequate to prevent circulation following WPV introduction.
- The potential for re-introduction of WPV from the current outbreaks in West and Central Africa, which is very real given the mobility of populations across this block of countries. Mobile and migrant populations are capable of moving wild poliovirus long distances, and being less likely to be effectively covered by immunization or surveillance. The detection of long chain WPV in different states points towards the importance of population mobility and the potential for missing transmission in mobile groups.

Conclusions and Recommendations

In framing its conclusions and recommendations the ERC has attempted to address all of the questions posed by the national programme. The conclusions presented below are framed in the context of those questions.

Eradicating polio

Population immunity threshold for interrupting transmission

Modelling from field efficacy studies of vaccines suggests that in Nigeria if > 80% of children are immune to a given poliovirus type, prolonged circulation is unlikely. The force of infection is higher in densely populated settings and therefore immunity in urban and peri-urban slum areas may need to be higher, and as uniform as possible, to ensure there is no sustained transmission. Achieving these levels of population immunity requires high coverage with multiple doses of OPV. Data on immunization status of non-polio AFP cases still shows significant coverage gaps in several states, and this means that immunity levels in these areas (including Kano, with its large and dense urban and peri-urban population) are under the threshold necessary to be confident of stopping transmission. Of special note, coverage is not adequate to achieve the needed level of population immunity in the 85 high risk LGAs.

Strategies that should be implemented to achieve the population immunity threshold required to interrupt wild poliovirus circulation

The ERC has regularly re-affirmed that the quickest way to raise population immunity is through SIAs. This strategy has been demonstrating its effectiveness during the past 12 months. There are three elements to an SIA strategy, the first is the frequency and timing of rounds, the second is the vaccine used, and the third is the quality, or coverage of the target group achieved. With careful use of the different Oral Poliovirus Vaccine formulations now available to the programme, and with consistently high coverage of target groups, this strategy will achieve the population immunity threshold necessary to stop transmission. The ERC does not believe that the number or frequency of large scale SIAs should be reduced prematurely.

While stopping WPV transmission in Nigeria in 2010 is feasible, it will be impossible to be confident that all polio is gone for at least 6 to 12 months following the last case, depending on the serotype. **For this reason, and to insure against the possibility of transmission continuing at low levels, the national programme should plan a full set of activities through to the middle of 2011.** The level of activity can be reviewed and amended at a later stage depending on the epidemiology.

Guarding against complacency

The ERC re-iterates that if the remaining coverage and quality gaps are not addressed, the conditions to stop transmission in 2010 will not be met. The ERC has regularly warned that in previous years, periods of complacency have led to loss of programme momentum, upsurges in WPV transmission and the spread of WPV to polio-free areas of Nigeria and to other countries. **The progress currently being achieved must be consolidated and accelerated in 2010 to ensure that polio eradication in Nigeria is completed.** The ERC continues to warn strongly against

any diminution of effort; while understanding the pressures polio eradication places on national and state governments and partners, **only the completion of eradication can bring the full benefit of all the efforts made to date.**

Government coordination and engagement

Recommendations:

1. The ERC urges the Federal and State Governments to continue to take a leadership role on polio eradication, to honour the Abuja Commitments, to report on them on a quarterly basis, and to make every effort to ensure accountability of Local Government authorities for reaching every child.

2. The strategic priorities for polio eradication for the coming 12 months are:
    1. Addressing the quality and coverage gaps in the persistently under-performing 85 high risk LGAs
    2. Maintaining high levels of population immunity in all states through appropriate SIAs and through strengthened routine immunization
    3. Responding rapidly and effectively to any new WPVs or cVDPVs with high quality mop-ups
    4. Maintaining high quality surveillance to ensure that any poliovirus is rapidly and reliably detected

3. State and LGA Task Forces for polio eradication and immunization should be formed and functioning in all states by the end of the second quarter of 2010, as these task forces will be vital in strengthening immunization services.

4. The Government should continue to maintain a rolling 12 month planning timeframe for polio eradication activities.

Engagement of traditional leaders

Recommendations:

5. The national programme and partners should continue their efforts to fully engage traditional leaders in polio eradication activities, given the clear impact that their engagement has had on improving access to children. The lessons learned should be applied to those areas where traditional leaders are not yet fully engaged.

Supplementary Immunization Activities (SIAs) Schedule

In developing recommendations for SIAs the ERC carefully considered the questions posed by the Executive Director NPHCDA, the activities conducted in 2009 and early 2010, and the recommendations of the 18th ERC meeting. The recommended SIA schedule is intended to create high levels of immunity to all circulating polioviruses. **The recommended schedule should be regarded as flexible enough to be varied according to changes in epidemiology or vaccine supply.**

Recommendations:

6. The ERC recommends the following SIA schedule:

2010

- April: the planned sub-national IPD should target all states in the northern zones. The vaccine of choice is bOPV, in the event that inadequate supplies of bOPV are available, the endemic states should be prioritized for this vaccine, and mOPV1 used in other states as the risk of WPV1 remains real.
- May/June: the planned sub-national IPD should target all states in the northern zones. The vaccine of choice is bOPV.
- June/July: a large scale mop-up targeting highest risk states, extent and choice of vaccine (tOPV or bOPV) depending on epidemiology.
- September: a sub-national IPD targeting all states in the northern zones. The vaccine of choice is bOPV.
- October: a sub-national IPD targeting all states in the northern zones. The vaccine of choice is bOPV.
- November: a round should be carried out in conjunction with the planned Child Health Days. The vaccine of choice is tOPV.

In the event that bOPV is unavailable for any of the recommended rounds, the appropriate mOPV or tOPV should be used, depending on the epidemiology. The timing of use of tOPV can be varied dependent on the epidemiology of cVDPVs, and on the availability of vaccine. The extent of the rounds from September onwards can be varied depending on the epidemiology, but at minimum should cover the endemic states.

2011:

- Two national rounds should be carried out in the first quarter of 2011. One of these rounds should use tOPV and one bOPV. These rounds could be held in conjunction with planned national measles campaigns or Child Health Days.
- Two sub-national IPDs should be planned in the first half of 2011, with the vaccine of choice dependent on the epidemiology.

Mop-ups

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

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

Improving SIA quality and reaching more children

Recommendations:

8. **Specific actions must be taken to address the issue of the 85 under-performing LGAs** with objective of reducing the proportion of wards with more than 10% missed children to less than 10% in all of these LGAs by the June IPD round, and to sustain that figure in all subsequent IPDs.:

- **LGA-specific plans should be prepared in all 85 high-risk LGAs before the April IPD round,** identifying actions to improve IPD quality, local advocacy and coordination with traditional leaders, logistics, supervision, monitoring, and social mobilization. Plans should be updated prior to each IPD round.
- The ERC requests Traditional Leaders to ensure that 100% of Ward and Village Heads play a supervisory role in IPDs in HR/VHR LGAs, and to track indicators of their involvement closely.
- State Governors are again urged to convene meetings of LGA Chairmen of high risk LGAs immediately prior to each IPD round, to review past performance, identify problems, and decide on solutions.
- LGA Chairmen should chair daily review meetings during IPDs to ensure problems are identified and addressed and this indicator should to be closely monitored and reported on in national and international fora.
- The implementation of the HR LGA plans should be closely monitored at LGA level (evaluation of progress at minimum very month), State level (a review of progress against HR LGA plans at minimum every 2 months) and Federal level following each IPD round. If at the time of the national level review the progress is considered inadequate, special activities (including targeted rounds) in these LGAs should be implemented to ensure all children are reached.

9. The proportion of under-immunized children must be maintained at less than 10%, and the proportion of children with more than 3 doses increased to at least 80%, in all states by the end of the second quarter of 2010. **Particular attention should be paid to those states (Zamfara, Kano, Katsina, and Borno) which still have high proportions of under-immunized children.**

10. Independent monitoring should remain the standard mechanism for assessing SIA quality and immediately responding to quality gaps. **As a standard response, in any ward where monitors find more than 10% missed children following an IPD round the activity should be repeated.** This process should be documented according to a standard format, including the number of children reached in the repeated activity, and reported following each IPD round.

11. Independent monitoring should be supplemented by LQAS in those areas where there are significant quality concerns or where there is contradictory data. LQAS should be conducted in:
- a good sample of high risk LGAs every IPD round, including in particular urban and peri-urban high risk LGAs
- in any area reporting poliovirus or with persistent surveillance quality problems
The results should be widely publicized and used in advocacy with State and LGA officials.

12. All states, including non-endemic states, should review their information on mobile and migrant populations, to ensure that these populations can be mapped, that nomadic and migrant routes and time periods are known, and that provision is made to reach these groups with immunization and surveillance.

Surveillance & Laboratory

Through 2009, surveillance system consistency has improved. The proportion of LGAs meeting both surveillance indicators (NP AFP rate >2 and specimen collection

rate >80%) has risen from 78% in 2008 to 86% in 2009. All 6 geographical zones in Nigeria now have at least 80% of LGAs achieving both targets. Non-polio enterovirus isolation rates remain adequate and vaccine virus isolation rates have risen significantly in 2009 (reflecting both increased exposure of children to vaccine virus and laboratory capacity to isolate poliovirus). The national programme pursues an active policy of peer surveillance reviews at state level, which have been followed by improvements in consistency of surveillance across LGAs. However, surveillance gaps remain, as shown by the detection of long genetic chains in wild poliovirus in 2009 ('orphan viruses'), and these must be addressed to ensure full confidence in surveillance.

Recommendations:

13. The following actions should be taken to ensure that surveillance system quality is high and consistent:
    - the national programme should immediately analyze data on trends in Sabin and NPEV isolation, by state, and for HR/VHR LGAs, to determine if there are any unusual patterns of isolation
    - any orphan virus should trigger an immediate detailed investigation, including a local surveillance review, with particular concentration on vulnerable populations at risk of being missed by the surveillance system.
    - given the link between inconsistent surveillance performance and the detection of orphan viruses, full reviews should be carried out in all LGAs not meeting both surveillance indicators, and the results documented to ensure that any identified problems are addressed
    - a mechanism should be developed to validate the authenticity of AFP cases and stool samples, with a certain proportion of cases/samples validated every month
    - state peer surveillance reviews are helping to improve consistency; a schedule should be developed for the systematic continuation of these reviews in 2010.

14. Additional information for surveillance should be generated through:
    - the comprehensive assessment of the potential for supplementary environmental surveillance in key areas (e.g. Kano Municipal); if appropriate, a plan should be developed for introduction in the first half of 2010.
    - the assessment of levels of antibody to poliovirus in children through a seroprevalence survey in the highest risk states in 2010, to validate evidence of declining poliovirus circulation and establish a baseline for population immunity.

15. An international surveillance review should be planned for the first half of 2011.

16. Laboratory workload and performance should continue to be monitored, and adequate support provided to the national polio laboratories to ensure continued high quality and timely provision of results to guide programme decisions.

Social Mobilization and Communications for polio eradication

The ERC recognizes the progress made in communication and social mobilization for polio eradication in Nigeria. Of particular importance has been the collaboration with traditional and religious leaders. The ERC encourages NPHCDA to continue and expand its institutional support to this group for primary health care interventions in

general, and immunization in particular, with standard mechanisms to guide activities at national, state, LGA and ward levels.

Recommendations:

17. Specific, tailored strategies should be developed for high risk and very high risk LGAs, and clear parameters/indicators established for scaling up and implementing strategies in these areas:
    - communication and social mobilization activities and objectives should be integrated into specific HR/VHR LGA plans and updated and implemented for every SIA based upon trend analysis of campaign indicators and other forms of social data
    - plans should address major reasons for missed children, with activities put in place to reduce both missed children and non-compliance.
    - in particular specific actions should be taken in conjunction with traditional leaders to engage Ward and Village Heads, with the objective of increasing community demand and reducing levels of non-compliance.
    - standard analyses of social data, including trend analysis, qualitative analysis and narrative descriptions of progress and challenges all high risk LGAs should be prepared after each SIA round; this data should be included in quarterly communication updates from Ward to LGA to State to National levels, with reference to the indicators in the 2010 communication strategy and work plan.

18. The SMWG at the national level and in high risk states should continue to explore opportunities to expand partnerships with civic partners, such as media agencies and community based organizations such as FOMWAN that have reach into areas that are persistently high risk for both PEI and routine immunization.

19. The NSMWG should identify and support priority research to better understand opportunities and challenges for PEI in Nigeria. This should include specific research to explore and disaggregate reasons for missed children in priority high risk communities, including nomads and refusal areas, possibilities for community generated and disseminated messages, and efficacy studies to evaluate channels and messages, such as community dialogues, film shows and text messaging, to identify those activities that have potential for maximum reach and impact.

Strengthening Immunization Systems

The ERC met for a full day to review the situation of routine immunization in Nigeria and received a range of presentations and information, from both Federal and State level, and from partners working on aspects of immunization systems strengthening.

The ERC recognizes that there is evidence of progress made by Nigeria in improving routine programme performance in 2009. However, immunization coverage in Nigeria is still not adequate. The ERC emphasizes that the maintenance of polio eradication in Nigeria will be dependent on strong routine services, as will the protection of the gains made in measles mortality reduction, and maternal and neonatal tetanus elimination. As the disease control strategies achieve further gains, routine

immunization will become increasingly important for the longer-term maintenance of population immunity.

Increasing immunization coverage, with a focus on reaching the unimmunized, is critical to achieving the health-related Millennium Development Goals (MDGs). Reducing the number of unimmunized children and women with traditional, new and underused vaccines will have a significant impact on mortality. The approved National Strategic Health Development Plan provides an opportunity for strengthening immunization, with achievable targets consistent with the MDGs.

Overall strategy for strengthening immunization in Nigeria

The ERC stresses the importance of a dual strategic approach to strengthening immunization in Nigeria, that both raises coverage ***and*** strengthens the immunization system. There is a place for campaign like activities such as Child Health Weeks, IPDs, National Measles Campaigns, MNT campaigns, and others. Nonetheless these strategies, while indispensible for disease control and rapidly raising coverage, must be supported by a strong system for regular delivery of immunization services through health facilities and outreach from those facilities.

Recommendations:

1. The ERC considers that a comprehensive plan and agenda of accelerated disease control activities must be established as part of the NPHCDA multi-year plan to optimize coordination across the broad range of immunization activities now being promoted in Nigeria. Close coordination of these activities will be required to ensure maximum impact.

2. National targets for immunization coverage should be aligned with the National Strategic Health Development Plan (NSHDP), to ensure a consistent message is given to the community, political and traditional leaders, and partners.

Implementation: reaching children with vaccine

The ERC considers that the experience of planning and implementing activities to reach every village and every child developed through polio eradication activities can be used to significantly strengthen planning and implementation of routine services. There are states that have succeeded in strengthening routine immunization in 2009 using the same systematic planning and monitoring approaches.

Recommendations:

3. Expansion of the REW strategy to the remaining LGAs must be completed. The priority for implementation should be the high risk LGAs, which have the highest proportions of unimmunized and under immunized children. The ERC would like to continue to receive progress reports on the status of REW implementation at LGA level, and any evidence of impact on session frequency and coverage.

4. ERC endorses the *1, 2, 3 strategy*, that is the strategy of implementing and monitoring (a) 1 routine session/week in all Health Centers implementing RI services, (b) 2 outreach sessions/week from all Health Centers implementing RI

services, and (c) 3 LGA-level supervisory visits/month to supervise planned routine immunization activities. Immunization sessions and vaccine availability should be monitored closely, with results fed back to States and LGAs to identify areas where routine sessions are inadequate, for appropriate intervention.

5. The ERC also endorses the strategy of delivering immunization in conjunction with Child Health Weeks, as a means of rapidly raising immunization coverage.

6. States should review and update their plans of action for the delivery of routine immunization services, taking into account data on the monitoring of immunization sessions and vaccine availability, to improve the consistency of delivery of services. Poor performing areas and areas with large numbers of unimmunized children should be identified and prioritized in these plans.

7. State and LGA Task Forces potentially have a major role in sustaining implementation of immunization services; all states and LGAs should have task forces, and their mandate should to include the full immunization agenda, by the end of 2010.

8. Every State & LGA should have a budget line item for routine immunization, to ensure the capacity to implement fixed and outreach immunization sessions; this should be tracked at State & Federal levels, as part of the monitoring of the Abuja Commitments.

9. Traditional Leaders should be engaged by Federal, State, and LGA authorities to systematically promote & support the broader immunization agenda, building on their very successful role in polio eradication.

10. The NSMWG should ensure that aspects of the 2010 work plan on routine immunization are supported, and expand activities at state and LGA level to include specific objectives for improving routine immunization through improved service delivery capacity and community demand.

Vaccine security and quality

The ERC acknowledges the work done on assessing cold chain adequacy and vaccine supply management, and welcomes the development of the 2010 plan by the Logistics Working Group. The ERC also notes that 26% of LGAs and 30% of health facilities experienced vaccine stock outs in 2009, and that there are significant improvements needed in the vaccine management, cold chain, and logistics system, particularly in light of the introduction of new vaccines.

Recommendations:

11. A detailed review of vaccine forecasting and logistics, including the requirement estimation and distribution mechanism for vaccines and supplies should be conducted with a view to improving the reliability of availability at the peripheral level.

12. The capacity of logistics officers involved in managing vaccine supply, cold chain, and logistics at national, state, and LGA level should be strengthened through a systematic training process. This process should begin as soon as possible.

13. The estimation of cold chain capacity needed as the programme expands should be finalized, and a technical consultation held to support decisions on cold chain equipment types and distribution.

14. Consideration should be given to reactivating Zonal Logistics Working Groups, to provide support to states in managing logistics issues.

Data quality

The ERC was impressed by the work being done to improve data quality, while acknowledging that there are still significant data issues. Major ongoing data quality problems still exist. The ERC reiterates the need for reliable data to inform programme decisions and strengthen immunization.

Recommendations:

15. The ERC noted that DHS and similar data are the gold standard for assessing immunization performance (coverage), and should guide further improvements to data collection and accuracy.
16. Monthly data quality self-assessment (DQS) and other activities to validate reported administrative coverage data should be continued, while recognizing the limitations of this tool in improving accuracy if the underlying coverage data are flawed. Monthly data review meetings should be held in every state and LGA to review data quality and reconcile problems. Federal level participation in these meetings should be periodically planned, particularly in high risk LGAs.

Accelerated Disease Control

The ERC noted the report received on MNTE, and welcomes the convening of a Special Measles Consultation & requests to be formally informed of the outcomes to guide the future work of the ERC.

Recommendations:

1. The ERC urges that NPHCDA closely coordinate disease control activities to ensure maximum impact. It is necessary to develop a comprehensive plan and agenda of accelerated disease control activities as part of the NPHCDA multi-year plan to optimize coordination across the broad range of immunization activities now being promoted in Nigeria.

Next ERC Meeting

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