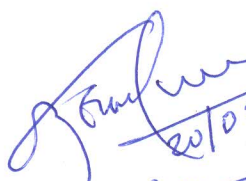
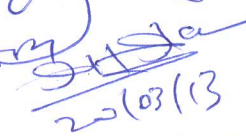






**25th Meeting of the Expert Review Committee (ERC)
On Polio Eradication & Routine Immunization
in Nigeria**

Abuja, Nigeria

19 – 20 March, 2013

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2. Prof. I. HOGAN ITAM  20/03/13
3. UMARA SHETTU  20/03/2013
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Executive Summary

Nigeria has made tremendous progress in reaching more children, even in the very high risk areas, with polio immunization. This improvement in performance has been the result of a massive effort by the Government and partners. In particular, since its establishment the Presidential Task Force has been instrumental in overseeing the implementation of National Emergency Action Plans (NEAP) for 2012 and 2013, and in monitoring the Abuja Commitments. This oversight has been enhanced by the new tools for monitoring implementation of the activities in the NEAP, and the information gathering and analysis functions performed by the new Emergency Operations Centre (EOC). The national programme has developed a strong NEAP for 2013 based on the experience of 2012.

However, serious challenges remain that could yet de-rail polio eradication in Nigeria. Despite the program improvements, Nigeria has still reported over half of all global cases in the last 6 months. In some areas key elements of the emergency plan are not being implemented, including those related to the responsibilities of local and state government authorities. Against the overall trend of improvement, there remain high risk LGAs and wards that have stagnated or even declined in performance over the past 6 months; these areas are currently inadequately characterized and understood. The re-appearance of well-organized anti-immunization propaganda requires a coherent and effective response. Last but by no means least, the recent upsurge in security incidents in key states, especially Borno and Kano, have delayed activities and hampered access to high risk areas, and the programme must develop specific strategies to overcome the constraints due to insecurity.

The ERC recognizes four distinct situations, requiring specific approaches:

- **Areas where performance is improving (the majority of LGAs):** In these areas implementation of the 2013 NEAP must be rigorous and closely monitored, and response to new anti-immunization propaganda must be coherent and rapid.
- **High risk, fully accessible areas failing to improve:** In some key high risk LGAs progress has stalled or performance has declined. Intensive work is required to identify these areas and to develop and implement specific plans of action to rapidly improve performance.
- **Outbreak zones:** In non-endemic areas (FCT, Nassarawa, Bauchi) re-introduction of virus poses the risk of extended transmission and further spread. Rapid and high quality outbreak response in these areas is essential to stop transmission and eliminate that risk.
- **Security affected LGAs:** Some areas are now affected by worsening security which has disrupted activities and reduced access for immunization. Specific plans are required for these areas to define access and identify special strategies to allow programme implementation to continue.

The ERC remains convinced that Nigeria has a historic opportunity to stop poliovirus transmission. This can be achieved despite the challenges, through enhanced oversight by Government at national, state, and LGA levels, full implementation of the 2013 Emergency plan, and development and implementation of specific strategies and plans for under-performing and security compromised areas. The ERC offers the following major recommendations for urgent implementation through end-2012:

Major Recommendations:

- **Oversight:** The Presidential Task Force's monitoring of implementation of the 2013 NEAP by States and LGAs is critical and the ERC urges active follow up each IPD round; national and state EOCs should track engagement of State and LGA leadership and identify issues for corrective response from the PTF.
- **Addressing underperformance:** All endemic states must immediately identify the VHR & HR LGAs and wards that have stalled or are deteriorating in the quality of programme delivery, and develop a specific intervention plan by end-April.
- **Operating in insecure areas:** The PTF and concerned STFs should immediately include civil government & security officials to support development of a polio security plan covering the affected LGAs by the end of April, incorporating flexible immunization strategies; the ERC urges Kano and Borno to re-start polio immunization activities as soon as possible to ensure that momentum for eradication is maintained.
- **Aggressive SIA strategy:** The ERC endorses the national SIA plan for up to 8 sub-national IPDs in the period April to December 2013, noting that the selection of areas to be covered and vaccine of choice for any particular round should be decided based on the developing epidemiology.
- **Addressing the anti-immunization lobby and creating demand:** The national programme should rapidly respond to anti-immunization propaganda through positively concluding on-going engagement with the anti-immunization group, intensifying activities to refute false allegations, and creating demand for immunization services by undertaking a systematic programme to engage religious leaders in HR States, LGAs, and wards, as part of the process of building community ownership.
- **Outbreak response:** Every case of WPV1 occurring outside the key endemic states, and every case of WPV3 or cVDPV2 occurring anywhere in Nigeria, *should be regarded as an outbreak and should trigger an immediate and full mop-up response.*
- **Financing:** The Government of Nigeria and partners should move immediately to place the finances of the polio eradication program on a firm footing through finalizing existing processes and commitments and pursuing new innovative financing mechanisms, including increased drive for support from local entrepreneurs and businesses
- **Ensuring OPV supply:** The Government of Nigeria should license all available bOPVs from pre-qualified suppliers as soon as possible, and ensure that all necessary waivers are in place for bOPV for the coming IPD rounds.
- **Harmonized immunization plans:** Building on the work done to date, a comprehensive activity plan should be prepared every year, commencing in 2013, covering all immunization activities and exploiting as far as possible the

synergies between the activities, in particular in aligning training, microplanning, communications, logistics & cold chain activities.

Introduction

The 25th Expert Review Committee for Polio Eradication and Routine Immunization was convened on 19-20 March, 2013 in Abuja. The world in 2012 reported the lowest number of polio cases ever since the global eradication initiative began; but Nigeria reported more than 50% of those cases. The ERC is reviewing the program in the context of solid progress in many areas, but also of threats to continued progress in some key areas posed by failure to implement emergency plan strategies; rising insecurity; and a resurgence of anti-immunization propaganda.

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

1. What strategies can the ERC recommend in addition to those outlined in the 2013 PEI Emergency plan to ensure program implementation in security compromised areas?
2. What additional strategies can the ERC recommend to address the current anti-OPV challenges?
3. How do we address the funding gap as outlined in the 2013 – 2015 FRR
4. How do we ensure adequate vaccine security for the program considering current global shortage?

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 25th meeting of the ERC.

The ERC would like to acknowledge with the greatest respect the sacrifice made by health workers and vaccinators who died as a result of senseless attacks in early 2013, and to offer sincere condolences to their families and loved ones.

Report on the 24th ERC Recommendations

The ERC reviewed the report on the status of implementation of the 24th ERC recommendations and congratulates the national program on progress in implementing key recommendations. The ERC believes that the Presidential Task Force has had a major impact not only in the oversight of the implementation of the National Emergency Action Plans, but also of the implementation of ERC recommendations. With respect to the plans, the roll out of the new house based microplanning process was achieved in the 11 high risk states, the partner and government surge support has been deployed, and processes have been developed to track implementation of the NEAP through the new Emergency Operations Centre (EOC). Some key recommendations that require further work include the development of plans for operating in insecure areas, the full roll out of the new vaccinator training module, and the implementation of the REW strategy in key high risk LGAs.

Current epidemiological situation

In 2012 a total of 122 cases due to wild poliovirus (103 due to WPV1 and 19 to WPV3) were reported from 13 States. Additionally 8 cases due to circulating Vaccine Derived Poliovirus type 2 (cVDPV2) were reported from 3 states. Transmission of WPV was concentrated in the endemic northern states, with 85% of cases reported from just 6 states, Katsina, Kano, Kaduna, Sokoto, Jigawa, and Borno; the first three of these states alone accounted for two-thirds of all reported cases. Within the affected states, transmission was further concentrated, with just 12 Local Government Areas (LGAs) reporting 45% of all cases.

To date in 2013 transmission is significantly lower than in 2012 but still higher than in 2010 and 2011. In 2013 a total of 8 WPV cases, all WPV1 had been reported by 20 March, from 5 states, FCT, Nassarawa, Bauchi, Yobe, and Borno. The cases in FCT and Nassarawa are part of an ongoing outbreak in these areas following introduction of wild poliovirus in 2012; the case in Bauchi can be considered a new outbreak in a previously polio-free area. The only endemic states reporting cases to date are therefore Borno and Yobe, which account for 5 of the 8 cases. No cVDPV2 has yet been reported in 2013.

WPV1 is the dominant serotype. WPV3 was last reported in November 2012; only one case of WPV3 has been reported in the past 6 months. However WPV3 was also reported in test environmental samples from Lagos in November 2012. The most recent cVDPV2 was reported in Kebbi in November 2012, but environmental samples from Sokoto have been positive as late as January 2013.

Programme developments

The ERC noted some key developments since their last meeting:

- Since its establishment the Presidential Task Force has been very active in overseeing the implementation of National Emergency Action Plans (NEAP) for 2012 and 2013, and in monitoring the Abuja Commitments.
- This oversight of the national programme has been enhanced by the establishment of the national Emergency Operations Centre (EOC), and in 5 key States by State EOCs; the dashboards and other monitoring tools developed to track preparation and implementation indicators offer a rapid mechanism for detecting issues so they can be addressed. The EOCs offer a forum not only for monitoring indicators of implementation, but also for the collection and analysis of programmatically important data.
- The new household based microplanning process has been fully rolled out in the endemic states, and has been augmented by the use of GIS technology in key areas. Improvements in LQAS results from the October 2012 round onward suggest that this process is already having an impact in reaching more children.
- A household based communications strategy has been rolled out in high risk wards particularly in the north-west, and expansion of the network of Volunteer Community Mobilizers is continuing; there is already some evidence of the impact of this strategy in reducing missed children in high risk communities. The recent management review of the network will provide guidance for improving its impact.
- Much work has been done to identify and track underserved communities to ensure that they are included in planning and that they are reached with vaccine; there is good evidence to indicate that 10 - 20% of the children in the identified communities had never been reached with immunization prior to this initiative.

- A new training package for vaccinators has been developed and is targeted for roll out in the coming months, aimed at significantly enhancing team performance.

Key Risks

The ERC also, however, has identified key risks to achieving polio eradication in Nigeria, as follows:

- Any relaxation in effort, or failure to fully implement the 2013 NEAP, in particular any relaxation of engagement and oversight of Federal, State, and LGA governments, will significantly imperil the initiative at this critical stage
- The failure of some very high risk and high risk LGAs and wards to improve performance, particularly since several of these LGAs are densely populated and constitute a real risk for sustaining transmission of wild poliovirus and cVDPVs
- The recent spate of cases in non-endemic states, which if not responded to vigorously and effectively, have the potential to turn into sustained outbreaks
- Insecurity in key endemic states which has the potential to restrict access for immunization activities, and which without careful and specific planning could delay and disrupt eradication activities
- A resurgence of anti-immunization propaganda which, if not responded to rapidly and effectively, could cause an increase in non-compliance and undo much of the good work that has been done in 2011 and 2012.

Conclusions and Recommendations

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

Despite the increase in transmission of polio in 2012, from the second half of 2012 **there is clear evidence that the programme in Nigeria is reaching more children with polio immunization, and more consistently, than ever before.** Most encouragingly, the ERC noted that **even in the 107 very high risk LGAs, the evidence of improved overall performance is strong.** Data from multiple sources are in agreement on improved performance and an improving immunity profile, and genetic data demonstrates continued restriction of the number of circulating clusters of WPV1 and WPV3 in 2012. Independent analysis also corroborates this conclusion, in particular the Global Goods analysis released in March 2013.

This improvement in performance has been the result of a massive effort by the Government and partners. The tactical changes and improvements in microplanning and monitoring have been coupled with efforts to improve team performance, with efforts to identify and reach underserved communities and with household level communications strategies, and the whole has been driven by much better oversight at LGA, State, and Federal levels, assisted by new tools and by the information gathering and analysis functions performed by the new EOC. The national programme has developed a strong Emergency Plan for 2013 based on the experience of 2012, and is functioning better than at any time since the formation of the ERC.

Yet serious challenges remain that could yet de-rail polio eradication in Nigeria. Improved performance must be maintained for an extended period of time in order to attain and sustain adequate levels of population immunity. Despite an overall significant improvement, in some areas key elements of the emergency plan are not being implemented, including those related to the responsibilities of local and state government authorities. Against the overall trend, there remain high risk LGAs and wards that have stagnated or even declined in performance over the past 6 months; these areas are currently inadequately characterized and understood. The re-appearance of well-organized anti-immunization propaganda requires a coherent and effective response. Last but by no means least, the recent upsurge in security incidents in key states, especially Borno and Kano, have delayed activities and hampered access to high risk areas, and the programme must develop specific strategies to overcome the constraints due to poor security.

The ERC recognizes four distinct situations, requiring specific approaches:

- **The majority of areas where performance is improving:** In the majority of LGAs in the endemic states, including high risk LGAs, there is solid progress. This progress must be maintained by rigorous and closely monitored implementation of the 2013 Emergency Plan, and by a coherent and rapid response to new anti-immunization propaganda.
- **High risk fully accessible areas failing to improve:** In some key highly populated high risk LGAs progress has stalled or performance has actually declined. Intensive work is required to identify these areas and to develop and implement specific plans of action to rapidly improve performance.
- **Outbreak zones:** In non-endemic areas (FCT, Nassarawa, Bauchi) re-introduction of virus poses the risk of extended transmission and further spread. Rapid and high quality outbreak response in these areas is essential to stop transmission and eliminate that risk.
- **Security affected LGAs:** Some areas, notably in Borno and Kano, are now affected by worsening security which has disrupted activities and reduced access for immunization. Specific plans are required for these areas to define access and identify strategies to allow programme implementation to continue.

The ERC remains convinced that Nigeria has a historic opportunity to stop poliovirus transmission. This can be achieved despite the challenges, through enhanced oversight by Government at national, state, and LGA levels, full implementation of the 2013 Emergency plan, and development and implementation of specific strategies and plans for under-performing and security compromised areas.

Recommendations

The ERC requests that the recommendations of the 25th meeting be taken in conjunction with recommendations of previous meetings which remain valid.

Fully implementing political oversight and commitment to achieving polio eradication in Nigeria

More than ever, the direct engagement and oversight by State Governors and LGA Chairmen is essential to sustain progress in improving areas, turn around stagnating

states and LGAs, and support access for vaccination in security compromised areas. The ERC recommends:

1. The Presidential Task Force should continue to closely follow the implementation of the Abuja Commitments by States and LGAs and actively advocate with those that are failing to implement agreed actions prior to each planned IPD round.
2. The State and LGA performance dashboard in the Federal and state EOCs should be used to track the engagement of the State and LGA leadership and flag issues for corrective response from the Presidential Task Force.

Implementing the 2013 National Emergency Action Plan

The 2013 NEAP incorporates the key elements needed to take Nigeria to eradication. In order to enhance the impact of the plan, the ERC recommends:

3. The national EOC and State Task Forces should adapt their management processes to the four distinct programme situations outlined above, and should focus on specific actions to be taken in LGAs and wards that are improving or performing well, those that are stalled, those that are affected by insecurity, and situations of outbreak response
4. In addition to the national EOC and the 5 recently established State EOCs, all other endemic and infected states should establish a State Operations Centre to coordinate immunization and response activities, along the lines of the EOCs, with assigned representatives of State Technical Teams and partners.
5. A specific process should be undertaken immediately in all endemic states to identify the very high risk and high risk LGAs and wards that are underperforming, stalled, or deteriorating in the quality of programme delivery. For each of these LGAs, a specific intervention plan should be developed by the end of April to address the reasons for underperformance, and they should be monitored specifically round by round.
6. The work being done to identify underserved and high risk populations and to incorporate them in IPD planning should be expanded, in particular to the north-eastern states, for the April and May IPD rounds; this process should continue to be carefully evaluated by state and national EOCs.
7. All opportunities should be taken to deliver additional doses of OPV, including between-round activities in scheduled major markets and associated motor parks, at festivals and ceremonies, at border and transit immunization posts, and by adding OPV to other campaign opportunities including the upcoming national measles campaign.

SIA schedule

8. The ERC endorses the national program SIA plan for the period April to December 2013:

- Up to 8 sub-national rounds (including targeted rounds)
- Up to 6 of these rounds should target all recently endemic states
- A minimum of one round should use tOPV but this should be increased if cVDPV transmission continues; the remaining rounds should use bOPV
- The selection of areas to be covered and vaccine of choice for any particular round should be reviewed and decided based on the developing epidemiology.

Outbreak response (mopping up strategy)

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. It recommends:

9. Every case of WPV1 occurring outside states with endemic transmission in the past 6 months (Borno, Yobe, Kano, Jigawa, Katsina, Sokoto, Zamfara, Kaduna), and every case of WPV3 or cVDPV2 occurring anywhere in Nigeria, ***should be regarded as an outbreak and should trigger an immediate response.***
10. The ERCs previous recommendations on speed (within 4 weeks of notification) and size (at minimum multiple LGAs and an overall target population of 1 million children) and interval (2-3 weeks between rounds) of mop-up response remain valid and should be followed. Where indicated, mop-ups should incorporate expanded age groups for special populations with very low immunity including nomad and underserved populations.
11. Consistent with previous recommendations, outbreak managers should be appointed at national and state level for each outbreak situation; these managers should be responsible for coordinating and managing their respective inputs and cooperating in the production and implementation of coherent and effective outbreak plans.
12. EOCs at national and state level should monitor the status of each outbreak response in accordance with previous ERC recommendations and global standards; in particular, the response to cases in FCT/Nasarawa and Bauchi should be monitored and status reported immediately to the Presidential Task Force.

Operating in areas affected by insecurity

The ERC notes that the 2013 NEAP includes strategies for continuing to operate in areas affected by security issues. In addition to those strategies, the ERC recommends:

13. The national program and state programs in the affected states should adapt to the new programme reality; the Presidential Task Force and State Task Forces should immediately co-opt appropriate civil government and security officials to provide input and assist decision making on program actions.
14. While appreciating the difficulties of their situations, the ERC urges that Kano and Borno re-commence polio immunization activities as soon as possible, using a

flexible mixture of strategies if necessary (see below), to ensure that momentum for eradication is maintained in these critical states.

15. Each affected state should develop a security plan for polio activities covering the affected LGAs by the end of April, and should analyse and track access at sub-state (LGA and ward) level, and changes in access over time, to inform decisions on programme delivery.
16. In areas affected by insecurity flexible immunization strategies should be adopted, as per the 2013 NEAP and experience in other countries; these could include:
 - Sub state rounds to cover LGAs and Wards that are accessible;
 - Staggered rounds to enable security measures to be taken area by area within affected states;
 - Permanent Polio Teams to provide a constant but low key community-based immunization presence;
 - Immunization from fixed sites where house to house activity is not possible;
 - Reduction in the length of the campaign to reduce the period of risk through use of larger numbers of teams;
 - Short Interval Additional Dose approach to rapidly increase population immunity when previously inaccessible areas become accessible.

Programme financing

17. The Government of Nigeria and partners should move immediately to place the finances of the polio eradication program on a firm footing through:
 - Completing the World Bank buy down process by mid-April 2013
 - Accelerating discussions on new innovative financing mechanisms with key partners (i.e. JICA Japan BMGF and local partners) with the aim of completing these arrangements by mid-2013
 - Rapidly reaffirming (by May) and planning release of GoN contributions for 2014 & 2015
 - Rapidly confirming (by May) international partner planned contributions for 2013 & 2014 to enable programme planning
18. The Government and implementing partners in Nigeria should ensure that there is the capacity in country offices to handle grant processes effectively, including the process of application, finalization of grants, and regular reports to donors.

Ensuring adequate vaccine supply

19. The Government of Nigeria should move to license all available bOPVs from pre-qualified suppliers as soon as possible, and UNICEF and GoN should ensure that all necessary waivers are in place for Serum Institute of India bOPV for the coming IPD rounds.

Improving surveillance and laboratory sensitivity

The ERC notes further improvements in the sensitivity of the national surveillance system, but notes also that gaps remain including in underserved and mobile

populations, and that there are issues with maintaining a very high standard of laboratory work under a high workload.

20. The national program should ensure that the underserved communities identified over the past 6 months, and incorporated in plans for immunization, are also incorporated into the surveillance system through the identification of appropriate informants.
21. The Government and partners, particularly WHO, should ensure:
 - that the national laboratories receive the technical and material support they need to continue to function at the highest possible level of quality
 - that the national laboratories are capable of managing under the circumstances of significantly increased workloads
 - where necessary, double testing of specimens at other accredited network laboratories is employed to ensure the quality of results
22. Environmental sampling is already making a significant additional information contribution to the national programme and this should be strengthened through:
 - initiating an investigation response to any sample positive for WPV or cVDPV to try to identify the source community; where such communities can be identified, active case search should be carried out, special immunization activities should target the community, and they should be prioritized in all future SIAs
 - any site found positive for WPV or cVDPV should continue to be sampled
 - as soon as circumstances permit, environmental sampling should be extended to Maiduguri given the importance of the north-eastern states in continued endemic transmission of WPV

Demand generation and the national communication strategy

There has been a major roll out of the LGA and household communications network in high risk states and although this is not complete there is already evidence of some impact on reducing missed children in the communities covered. The ERC recognizes that a review of the VCM network has just been completed and that the results will influence future communications planning.

23. The programme should continue the planned roll-out of the VCM network to high risk communities, taking account of the results of the recent review, but should also retain the flexibility to set up operations at LGA & ward level in key areas, in order to be able to engage communities on a broader scale and in particular to build local community ownership and acceptance for immunization.
24. There continues to be a need to better understand the reasons for children being chronically missed, to inform programme actions. Polling methodology and systematic investigations of chronically missed children (using recently developed tools) should be implemented commencing in April to build a better dossier of information on these children.
25. Vaccinator interpersonal communication skills (IPC) continue to remain a critical factor in reducing the number of missed children. The IPC module in the new

vaccinator training package should be strongly emphasized in the roll out of the training process.

26. The national programme should build on the work and mapping that has recently been undertaken to ensure the systematic engagement of religious leaders in high risk states, LGAs, and wards, as part of the process of building community ownership and responding to anti immunization propaganda. This process should be tracked and monitored from April.
27. The current revival of anti-immunization propaganda in some areas in high risk states requires a rapid and vigorous response, through:
 - initiating a proactive media programming to highlight the gains of the eradication programme
 - working together with community leaders to meet the demand, especially at community level in the affected areas.
 - engaging in low-key dialogue with those behind the propaganda to appropriately address their grievances and providing data e data to counter their incorrect information

Achieving broader immunization goals

The ERC considers that the harmonized immunization plan is a big step forward, for the first time outlining all immunization activities in the country, but it is only the first step towards a truly integrated and coordinated process.

28. An activity plan should be prepared every year, commencing in 2013, covering all immunization activities and exploiting as far as possible the synergies between the activities, in particular in aligning training, microplanning, communications, logistics & cold chain activities.
29. The Reaching Every Ward strategy implementation and in-between round activities in Very High Risk LGAs must make use of the polio surge capacity and the information developed through the new microplanning processes and community mapping, to ensure that all communities are covered by immunization services.
30. WHO & UNICEF at global and regional levels should move quickly to develop clear packages for country programmes, outlining ways in which polio expertise and experience can be used to benefit broader immunization goals.
31. In strengthening measles elimination activities:
 - in the current outbreak situation a strong emphasis should be placed on case management in affected areas, coupled with outbreak response immunization in areas with rising cases;
 - the most significant step in controlling measles in the longer term will be the national campaign later in 2013; strong planning for this campaign must commence immediately, incorporating the polio microplanning experience.