WPV & cVDPV2 cases by State as at October 28, 2011

Summary of WPV by Zones and States, onset 2010/2011

S/No	Zone	State	Week 43 2011				2011				2010			
			New Results Received this week				WPV1	WPV3	cVDPV2	Cum Total	WPV1	WPV3	cVDPV2	C To
			WPV1	WPV3	cVDPV2	Total								
1	NC	FCT	0	0	0	0	0	0	0	0	0	1	0	
2	NW	Jigawa	1	0	2	3	6	0	9	15	0	0	1	
3		Kano	1	0	1	2	11	3	7	21	1	0	11	1
4		Katsina	1	0	0	1	1	0	1	2	0	1	0	
5		Kebbi	0	0	0	0	4	4	0	8	2	2	3	
6		Sokoto	0	0	0	0	3	1	0	4	1	3	3	
7		Zamfara	0	0	0	0	1	0	1	2	0	5	1	
8	NE	Borno	0	0	0	0	3	2	2	7	4	0	2	
9		Yobe	0	0	0	0	2	0	1	3	0	0	1	
TOTAL			3	0	3	6	31	10	21	62	8	12	22	4

Latest onset of confirmed WPV 02-Oct-2011 from Mashi LGA; Katsina State.

One of the WPV1 in Kebbi State is from a contact that was investigated 79 days after onset of the index case.

22nd Meeting of the Expert Review Committee (ERC) On Polio Eradication & Routine Immunization in Nigeria

Abuja, Nigeria

13-14 October 2011

Executive Summary

The ERC is extremely concerned that **the upsurge in polio in 2011 places at risk the progress made since 2009**, and sends a clear warning that efforts to eradicate polio from Nigeria must be redoubled to ensure that the hard won gains to date are capitalized upon and expanded. In conformity with the African Regional Committee Resolution RC61/R4, the ERC calls upon the Government of Nigeria to consider ongoing poliovirus transmission as **a national public health emergency.**

- **Nigeria still has an excellent opportunity to stop transmission of all poliovirus,** but state and local government, oversight must be enhanced through the full implementation of the Abuja commitments, and the pace of implementation of key interventions in high risk areas must be accelerated in the coming 6 months. **It is absolutely imperative that the operations and communications lessons learnt in the past two years to improve the quality of immunization and surveillance be vigorously and effectively applied immediately.**

Transmission of poliovirus in the remaining foci, especially in Kano State which has historically been the reservoir of poliovirus in Nigeria, must be rapidly stopped. Children in the highest risk areas must not be missed during immunization activities and in the coming 6 months all high risk areas should achieve at least 90% coverage of children less than 5 years of age with 4 OPV doses or more. **There must be no tolerance for inadequate work in IPDs; poorly performing areas must be re-vaccinated.** At the same time, populations across the high risk states, and in the whole country, must continue to be protected against poliovirus.

Major Recommendations:

1. ***Identify, characterize, and reach unvaccinated children:*** specific action must be taken to identify and vaccinate children who are continuously missed in high risk areas during OPV campaigns, including special investigations to characterize non-compliant parents, improving microplanning and implementation through GIS/GPS mapping, revaccination of any ward failing to achieve 80% coverage, implementation of the Intensified Ward Communication Strategy, and rolling out community based mobilization specifically targeting non-compliant communities.

2. ***Sustain the OPV campaign strategy:*** An immediate high quality mop-up round in Kano and Jigawa should be carried out in late October; high risk states should be covered in conjunction with Child Health Weeks (CHWs) in November, and again in a subnational IPD in December; 2 national and at least 2 sub-national IPDs should be carried out in the first half of 2012.

3. ***Establish a framework of accountability for LGA Chairmen and Ward Heads:*** As part of implementing the re-affirmed Abuja Commitments a framework of accountability for LGA Chairmen and Ward Heads should be established, monitored by the special Task Force established by His Excellency the President.

4. ***Focus on the key Infected Zones - Kano/Jigawa, Borno/Yobe, Kebbi/Sokoto/Zamfara:*** concentrate technical support, advocacy and innovations in these key infected zones that are sustaining transmission.

Introduction:

The 22nd Expert Review Committee for Polio Eradication and Routine Immunization was convened on 13-14 October 2011 in Abuja, in the context of the urgent need to ensure that actions are taken to complete the job of polio eradication.

As part of their deliberations, the ERC considered some key questions:

- What are the implications for the national programme of the upsurge in polio in Nigeria in 2011 compared to the same period in 2010?
- How can the real reasons for children being always or regularly missed be more systematically identified and addressed?
- What key actions must be taken to address the persistent problems in high risk areas that are sustaining poliovirus transmission?
- How can the progress that is being achieved be accelerated to ensure that all children in high risk states are consistently reached with immunization in the coming 6 months?

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 22nd meeting of the ERC.

Report on the 21st ERC Recommendations:

The ERC noted the report on the status of implementation of the 21st ERC recommendations. The national programme and partners have made major efforts to address ERC recommendations, and made significant progress in some key areas, including with respect to recommendations on identifying and closing surveillance gaps, although of course this work is ongoing. The national programme continues to monitor and report on the Abuja Commitments, and the ERC notes the reaffirmation of those commitments by Federal and State Governments in 2011, but there are still clearly gaps against the indicators especially at LGA level. Implementation of the mop-up recommendations has been only partially achieved, although the ERC understands the difficulties of full implementation given the number of cases occurring during the high transmission season. The full recommended SIA schedule has been implemented, and there is continuing evidence of improvements in the immunization status of children in endemic states, however this improvement is uneven and far too slow and there remain very large numbers of under-immunized children in Nigeria. Certain elements of the recommendations have not been adequately addressed, and in particular the pace of change and implementation of innovations in high risk LGAs is slower than needed to eradicate polio.

Current epidemiological situation:

In 2011, as at 12 October, 34 cases due to wild poliovirus have been reported in Nigeria, 26 due to WPV1 and 9 due to WPV3, compared to 10 cases in 6 states at the same time in 2010. Six states, Kano (13), Kebbi (8), Jigawa (4), Borno (4), Sokoto (3), and Yobe (2) have reported cases, in 23 LGAs. Several LGAs have reported multiple cases, with one, Kumbotso in Kano State, reporting 7 cases. The current most active zones of transmission are in Kano, Jigawa, Kebbi, and Borno. At the time of the ERC meeting, advance notice of an additional 4 cases was received, including the first case in Zamfara in 2011.

WPV1 is the most widespread of the two WPV types, being reported from all six states, with **the largest cluster of cases coming from LGAs in and around Kano Urban.** Three genetic clusters of WPV1 have been identified, with the bulk of cases coming from a single cluster circulating in a band of states from Borno to Kano.

The nine WPV3 cases are from two genetic clusters, with the most active cluster circulating primarily in Kebbi, but also spreading as far as Borno and Kano states. The other cluster (2 cases) was reported only in Kano in mid-year.

Seventeen cVDPV2 cases have been reported with onset in 2011 from 6 states. The bulk of cVDPV2 cases are from a single circulating genetic cluster. Sustained circulation is occurring only in Kano and Jigawa, which have reported 6 cases each; Kano shows the broadest genetic diversity and is exporting cVDPVs to other states.

Transmission of all poliovirus types is primarily being detected in known high risk LGAs, most of which demonstrate consistent problems in achieving high immunization coverage during IPDs. Consistent with previous years, detailed case investigations show that polio cases, whether due to WPV or cVDPV, are overwhelmingly un-immunized or under-immunized.

Programme developments

The ERC noted some key developments since their last meeting:

- **National polio emergency plan.** A plan has been developed at national level with a major focus on improving immunization coverage of children in the highest risk areas of the country where there have been consistent quality problems; revitalizing State and LGA PEI Task Forces is identified as a crucial step in achieving this. The President has announced the formation of a special Task Force to support the implementation of the plan.
- **Continued overall improvement in polio immunization status.** Non-polio AFP case data shows that in high risk states more than 75% of children under five years of age now have received 3 or more doses of OPV, and the zero dose proportion has dropped to 4%; this is encouraging although the average figure masks significant gaps in key states (especially Kano and Borno) and high risk LGAs.
- **Systematic assessment of surveillance quality and plans to address gaps in key states.** Surveillance assessments have now been completed in 8 states and action plans developed to address the identified gaps.
- **New social mobilization and communications efforts.** The Intensified Ward Communications Strategy is being rolled out in key high risk areas; a national media campaign centred on 'The Polio Free Olympic Torch' is in full swing.
- **Continued efforts to advocate with and engage political leaders and improve accountability.** The Abuja Commitments have been re-affirmed in September, two years after the original accord was signed, during the visit of Mr Bill Gates. The immediate opportunity to engage political leaders at all levels is good.
- **The sustained engagement of traditional and religious leaders.** The engagement of traditional leaders remains a strong feature of the programme, although there remains much further scope for improving the impact of this.

Conclusions and Recommendations

Eradicating polio

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

The ERC is extremely concerned that the upsurge in polio in Nigeria in 2011 seriously threatens the progress achieved over the past 2 years. Consistent with the September 2011 African Regional Committee Resolution RC61/R4, the ERC calls upon the Government of Nigeria to consider ongoing poliovirus transmission as **a national public health emergency.** The ERC considers that the upsurge has occurred because key interventions to reach and immunize all children have not been adequately implemented particularly in the highest risk areas, that the pace of improvement in these areas has not been fast enough, and that information crucial to effective programme implementation has not been adequately collected and used. The real reasons why children are being consistently missed, particularly in persistently poor performing areas, requires further investigation and this critical information used to act to improve coverage.

The ERC wishes to emphasize that nonetheless the progress in Nigeria since 2009 is real; **Nigeria still has an excellent opportunity to stop transmission of all poliovirus;** but in order to achieve that goal, state and local government oversight must be enhanced through the full implementation of the renewed Abuja commitments, and the pace of implementation of key interventions in all high risk areas must be rapidly accelerated in the coming 6 months.

The most significant risk of a major resurgence in transmission in Nigeria is Kano. Despite progress in improving immunization status of children, the number of under-immunized children remains far too high in this densely populated state; **given Kano's history as a major reservoir of poliovirus transmission in Nigeria, continued transmission there area poses a significant threat to the whole country.**

As noted above, **a further major risk is the slow pace of coverage improvement in the highest risk LGAs.** Key high risk LGAs continue to perform badly in IPDs round after round, LGA Chairmen and Ward Heads in these areas are insufficiently engaged, and interventions designed to improve quality are not being well enough implemented. This is despite the fact that there are interventions that are demonstrating impact. Intensified microplanning, particularly through High Risk Operational Plans in high risk LGAs, and backed up by GPS/GIS technology, is identifying missed communities and ensuring they are included in activities. A new training process for immunization teams is being piloted. Intensified communications programmes in the highest risk wards are resulting in better immunization outcomes. Re-vaccination strategies in poor performing areas are demonstrating that quality gaps can be rapidly addressed.

The ERC believes that polio can be eradicated in Nigeria if the national programme and partners rapidly step up intensity to close the remaining quality gaps. The basic elements necessary for doing this already exist; the key will be ensuring effective implementation of existing known effective interventions, and gathering and using information to inform new interventions.

Strategic Priorities for the national programme

The ERC considers that the strategic priorities for polio eradication in Nigeria for the coming 6 months should continue to be:

- **Identify, characterize, and reach unvaccinated children:** specific action must be taken to identify and vaccinate children who are continuously missed in high risk areas during OPV campaigns.

- **Sustain the OPV campaign strategy:** An intensive OPV campaign strategy should continue to be implemented with the aim of ensuring that over 90% of children in all high risk areas receive at least 4 doses of OPV.

- **Establishing accountability for LGA Chairmen and Ward Heads in high risk LGAs:** A framework of accountability for LGA Chairmen and Ward Heads in high risk LGAs should be established, monitored by the special Task Force.

- **Focus on the key Infected Zones - Kano/Jigawa, Borno/Yobe, Kebbi/ Sokoto/Zamfara:** concentrate technical support, advocacy and innovations in these key infected zones that are sustaining transmission.

Recommendations

The ERC requests that the recommendations of the 22nd meeting be taken in conjunction with recommendations of previous meetings which remain valid, and urges the national programme and partners to fully implement pending recommendations from previous meetings.

Identifying and understanding chronically missed children

1. Special investigations must be carried out by joint agency teams to identify and characterize missed chronically children and communities through:
   - thorough investigation of **each 0-dose AFP & polio case & their communities**
   - **investigation of all wards with >25% missed children** (whether due to 'non-compliant parents', 'absent children' or other) to understand the root causes
   - establishing **full State & LGA lists of settlements**, and identifying settlements with significant 'non-compliant' communities
   - mapping & tracking of **migrant/mobile populations** in all 12 northern states, based on lessons to date.

Reaching missed children especially in high risk LGAs

2. The following specific actions must be taken to rapidly scale up and implement known effective interventions in high risk LGAs including:
   - review and update of **High Risk Operational Plans** before each IPD round including revision of settlement lists
   - **GIS mapping support for microplan revision** in all polio infected LGAs before the November round, extended to all high risk LGAs by January, with extension of GPS mapping of teams in key areas

- scale up the deployment of **independent supervisors** in all high risk wards by the December round to improve team supervision and in-process monitoring.
- implement the **Intensified Ward Communication Strategy** in all identified high risk wards by the January IPD round; wards selected should remain areas of focus for at least three IPDs and activities should continue until the ward is no longer high risk according the defined indicators for at least two IPDs in a row
- scale up the use of re-visit teams, market teams, and evening teams to increase opportunities to find and immunize missed children; the impact of these teams should be closely evaluated and reported to state and national levels

3. Mechanisms for engaging non-compliant parents and communities must be systematized and extended as follows:
- community based mobilization should be scaled up and implemented in **all known settlements where non-compliance is an issue** by the January IPD round, with the support of partner agencies; this should include the identification and deployment of local mobilizers and the use of Rapid Response Teams; the impact of these interventions should be closely monitored
- systematically implement the 're-do' strategy to address specific cases of non-compliance, with the support of local Rapid Response Teams
- ensure that **local religious leaders** are engaged in all settlements where non-compliance is a significant issue and include them in Rapid Response Teams

4. The **Enhanced Independent Monitoring** process should be strengthened through:
- review of the EIM process in all high risk states before the November round and amendment of the process as necessary; particular attention should be paid to the process of selection of senior monitors, and their training and supervision.
- continuing to supplement EIM by extensive LQAS following each round. Any LGA showing a discrepancy of more than 20% between LQAS and EIM should be targeted for a special investigation of SIA and monitoring quality.

5. Any ward where monitors find more than 20% missed children following an IPD round **should repeat the immunization activity.** Adequate reserve vaccine and other stocks should be held at national level to cover this eventuality. This process should be documented and reported at state and national level following each IPD.

Establishing accountability at local level

6. The ERC urges Government and Traditional Leaders:
   - To immediately establish **a framework of accountability for LGA Chairmen and Ward Heads in all high risk LGAs**, monitored by the special Task Force, to ensure they are engaged in ensuring that all children are immunized every round. The framework should include:
     - ensuring complete settlement lists & microplans
     - appropriate vaccinator and supervisor selection
     - addressing non-compliance with the support of rapid response teams
     - achieving LQA- confirmed coverage of greater than 90%
     - 100% of Ward and Village Heads involved in supervising IPDs
   - To **concentrate advocacy and innovations in high risk states** and intensively monitor the Abuja Commitments at LGA level in these states.
   - To **monitor the implementation of State Emergency Plans** for Polio Eradication in all high risk states.

- To continue to work with the **governments of neighbouring countries** to share information and plan cross-border activities.
- To provide **adequate resources** for polio eradication activities and maintain a rolling 12 month planning timeframe for polio eradication.
- To empower the **special Task Force** to monitor progress in all these areas and directly act to address identified problems.

7. The national programme and partners should ensure that **traditional and religious leaders** are engaged in polio eradication activities especially in **all high risk LGAs and wards** to ensure that every action is being taken to consistently reach and immunize all children.

Supplementary Immunization Activities (SIAs) Schedule

8. The ERC considered the SIA schedule in light of the epidemiological picture and the opportunity presented by the low transmission season over the coming 6 months. The recommendations should be regarded as flexible enough to be varied according to changes in epidemiology.

The ERC proposes the following schedule for the remainder of 2011:
- An intense mop-up round in infected and other selected high risk LGAs should be carried out in Kano and Jigawa using bOPV in the last week of October.
- An embedded sub-national round should be carried out in 12 high risk states in conjunction with the Maternal, Neonatal, and Child Health week in November, using bOPV.
- A sub-national IPD should be carried out in mid-December covering 8-12 highest risk states, using tOPV, taking into account the timing of the meningitis vaccination campaign in some northern states.

The ERC proposes the following schedule for 2012 for planning purposes:
- Two national IPDs, one round with bOPV and one with tOPV, in late January and late February.
- Two sub-national IPDs in 8-12 high risk states in April and May with bOPV.
- Up to 4 additional sub-national IPDs from mid 2012, with the final number of rounds, extent, and vaccine of choice dependent on epidemiology.
- IPD rounds should be supplemented by mop-ups as required (see below).
- This schedule should be reviewed and finalized at subsequent ERC meetings based on the evolving epidemiology.

Mopping up in response to circulating poliovirus

9. The mop-up strategy for the coming 3 months should be:
- any areas **outside the key transmission zone** that become re-infected should continue to respond with the intensified mopping up strategy recommended previously by the ERC.
- from February 2011 the mop-up strategy for the transmission zones will be re-assessed in light of the epidemiology and the programmatic situation.
- it is essential that the programme maintain a **rotating buffer stock of vaccines** (minimum 5 million doses of bOPV and tOPV) and other mop-up resources.

Closing surveillance gaps and detecting all transmission

10. The programme plans for identifying and closing surveillance gaps should be fully implemented with particular attention to the following:
- implementation of action plans to close surveillance gaps in high risk states following surveillance assessments must be closely monitored and reported on.
- rapid assessments should be carried out in further selected states (including in the south) in Q4 2011 and Q1 2010.
- a **full national surveillance review** should be carried out in Q1 2012, to review progress in identifying and closing gaps and improving surveillance quality.
- following the successful and informative experience in Kano, seroprevalance surveys should be expanded to other key high risk states to provide additional information on immunity to guide programme decisions.

The Broader Immunization Agenda

The ERC received presentations on strengthening immunization systems, new ways of managing funds, and new initiatives including the Maternal, Newborn and Child Health Weeks (MNCHW) and the midwives service scheme (MSS) and noted the range of activities undertaken by the NPHCDA, State Governments, and partners.

Following the recommendations of the 19th and 21st ERC Meetings a number of actions have been initiated by the national programme. The Routine Immunization Committee of NPHCDA has again reviewed the performance of States and prioritized 330 LGAs as high risk based on 2010 immunization performance (including the 109 polio HR LGAs).

However, the national immunization system is still weak. Major problems of stock outs of DTP, measles and BCG vaccines for routine immunization have continued in 2011, reducing programme effectiveness, although the ERC acknowledges that efforts are being made by the national programme to improve vaccine security and cold chain management. Questions about the reliability of data on coverage still exist.

The ERC again emphasizes that the long-term success of polio eradication in Nigeria will be dependent on strong immunization services. Increasing immunization coverage is a critical platform for maintaining the gains of polio eradication.

Recommendations

1. The ERC recommends the development of a **National Immunization Strategy,** in advance of the Vaccine Summit planned for mid-2012, building on lessons learned and taking into account all the strands of immunization activities in Nigeria.

2. Improvement of routine EPI services should be targeted at the highest risk LGAs identified by states, but **especially those LGAs infected with cVDPVs in the last 12 months;** recognizing the international implications of the ongoing cVDPV2 transmission, a report on efforts to improve routine in those LGAs should be made to the next meeting of the ERC.

3. The Federal Government should ensure **Vaccine Supply Security** by establishing in 2012 its 'first charge' for vaccines in the capital budget and ensuring timely release of that financing.

4. The *1, 2, 3 strategy*, (implementing and monitoring (a) 1 routine session/week in all Health Centres implementing RI services, (b) 2 outreach sessions/week from all Health Centres implementing RI services, and (c) 3 LGA-level supervisory visits/month to supervise planned routine immunization activities) **remains valid and should be fully implemented as part of REW.** Indicators to monitor implementation should be presented at the next ERC.

5. Traditional Leaders should continue to be engaged by Federal, State, and LGA authorities, particularly in the 330 high risk LGAs with large numbers of unimmunized children, building on their very successful role in polio eradication.

6. The national programme should continue efforts to improve data quality and data management through support to monthly review meetings at State and LGA level and periodic immunization coverage surveys.