

# **Report on Barriers to Polio Eradication in Nigeria**

## **Independent Evaluation Team for Nigeria**

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## *Executive Summary*

### **Background**

The adoption of the resolution by the World Health Assembly in May 2008 which “urged Nigeria to reduce the risk of international spread of poliovirus through intensified eradication activities”, and the conclusion by the ACPE in its meeting on 18-19<sup>th</sup> November 2008 that “Nigeria poses a high risk to international health”, formed the background, to the request by the Director-General of the World Health Organization, for a report by an Evaluation Team to identify the critical barriers that prevent polio eradication in Nigeria.

The Evaluation Team had the following Specific Objectives:

- To evaluate the primary challenges to achieving sufficient population immunity to interrupt remaining polio transmission,
- To determine which critical factors are compromising OPV coverage and immunity,
- To evaluate risks, consequences and responses to the international spread of wild poliovirus to previously polio-free areas, with particular attention to those with persistent transmission
- To propose area specific strategies for addressing the primary challenges,
- To outline the action at local, state and federal level, which the authorities should take to ensure the area specific strategies are fully implemented and stop transmission, and
- To outline actions that partners including WHO, UNICEF and other GPEI stake holders should take at the sub-national, national and international level to support the area specific strategies,

The activities carried out by the team included,

- A review of the available literature, policy documents and partnership frameworks and WHO data from its offices in Abuja, Gusau in the State of Zamfara, and Kano in the State of Kano,
- Meetings and discussions with officials, decision-makers and other stakeholders at Federal, State and Local government, including the Honourable Minister for Health, and a number of partners from other agencies like WHO, Unicef, and others, and
- Visits by sub-teams to a wide range of health facilities in both States, including hospitals, rural and urban health centres, vaccine stores, and observed routine and supplementary immunization activities.

### **Findings**

The Team’s findings were as follows:

- The Evaluation Team was impressed by the progress that has been made in polio eradication in Nigeria in the last 2 years. After meeting with several key officials

and Emirs at the various levels of government, the Evaluation Team found that, as a result of efforts such as the Abuja Declaration and advocacy campaigns, (by Federal, State, and Local governments, and international partners), the programme is now moving in the right direction, and with further support as described below, is capable of achieving polio eradication.

- Political, religious, and traditional leaders were now very supportive of the polio immunization campaign. Previous concerns or misconceptions about polio vaccine safety appear to have reduced and now have only a negligible influence.
- The Evaluation Team considered that management issues were the most critical barriers to the success of the Nigerian programme. These difficulties occur at all levels.
- Though there is commitment to the programme at higher level, this is not always so at lower levels where there is great variation. For example in the State of Kano there are 44 Local Governments and 14 in the State of Zamfara. In some areas the programme is well supported, but in others support and supervision is weak. In some areas, funds for polio immunization activities were released very late, sometimes 24 hours before the start of activities, which has caused severe problems with implementing campaigns and mobilization of the community. In addition to the late arrival of operational funds, in many cases funds are inadequate.
- The performance of polio eradication activities is highly dependent on the commitment of the Local Government authorities, and the priority placed on polio eradication. Performance management was found to be weak in all the areas visited. Such problems indicate a lack of ownership of the programme and commitment to it.
- Inadequate mobilization of community groups, such as women's groups and others is another key barrier to increasing community demand for polio eradication.
- The Team observed that there were significant deficiencies existing in cold chain maintenance especially in Zamfara. Key examples were the non-functioning of solar refrigerators; many had no batteries, often because the refrigerators had been worked beyond their design specifications, being used to manufacture large quantities of ice-bricks. In places there was an insufficient number of deep freezers, and inadequate vaccine transport capacity.
- The routine immunization programme was found to be very weak in both the states. The SRIK project in the State of Kano found 69% dropout for DTP3, and coverage for fully-immunized children of only 5.5%. Further there is gross divergence between the official administrative data, survey and monitoring and supervision data on routine immunization.
- The recommendations made by Expert Review Committee on Polio Eradication and Routine immunization in Nigeria in their 16<sup>th</sup> meeting in October 2008 and 17<sup>th</sup> meeting in April 2009, were not fully implemented.

The suggested road map for the implementation of the recommendations is attached as appendix two.

A power point presentation can also be found in appendix three.

## Conclusions

The Evaluation Team considered that much work needed to be done to achieve polio eradication in Nigeria in the near future, in order to overcome the barriers described above.

Nevertheless, the Team considered the basic infrastructure in the sites visited was sound, and the Team considered that, with the implementation of the following recommendations that polio eradication in the near future is feasible. The Team recommends that

- Sustaining government commitment at all levels, but especially at the local level, can be greatly assisted by creation and use of “focal points” for polio eradication within Federal State and Local governments. These focal points can strengthen the system which is already in place in the country for monitoring the Polio Eradication i.e. at the Federal level , the Honorable Minister of Health, the Executive Governor at State level and the LGA Chairman at Local Government level. These focal points should have the authority to ensure that the job gets done and progress continues to be made. Some major stake-holders like WHO, Unicef and others may consider providing technical support to the focal point at the Local government level on a regular basis until interruption of transmission is achieved
- Enhancing the accountability and political stake of the partners in the polio eradication programme by ensuring close monitoring and follow up of polio eradication activities at high level, including by the President’s, Governors’ and Chairmen’s Offices at Federal, State and Local Government levels respectively.
- Ensuring good operational, financial and logistical programme management. This requires support and training of field staff and is especially important for the National Immunization Days.
- Ensuring strong community mobilization with involvement of all strategic partners including women’s groups, religious and traditional organizations, etc.
- A strong communication campaign with thorough implementation of a nationally integrated communication and social mobilization strategy at Federal, State and Local Government levels.
- Further strengthening of the existing surveillance, in order not to miss any chains of transmission, together with engagement of donor partners in monitoring and analysis. Strengthening the ICC governance structure and reviewing the 2004 strategic document to the existing epidemiological polio situation of 2009.
- Strengthening the routine immunization, as it will be critical in the maintenance phase of polio eradication,

The Team would like to emphasize strongly that, in its opinion, that polio eradication in the near future is very feasible in Nigeria.

The team acknowledges and would like to thank the government of Nigeria at all levels, the traditional leaders and religious institutions, other partner agencies such as WHO,

Unicef and others, and all the staff and people who discussed the issues with the team. The Team would like to thank the Nigerian Government for their hospitality and the frank and open discussions regarding the work to be done to achieve the goal of interrupting polio transmission.

## ***Background to the Evaluation***

### **Objective**

At the request of the Director-General of the World Health Organization, the Evaluation Team was to identify the critical barriers that prevent polio eradication in Nigeria.

### **Specific objectives of evaluation**

- To evaluate at local, state and national level the primary challenges to achieving sufficient population immunity to interrupt remaining polio transmission.
- To determine by reviewing the management, planning, supervision and implementation of polio campaigns, whether other critical factors are compromising OPV coverage and immunity.
- To propose area specific strategies for addressing the primary challenges and other major factors that are compromising population immunity
- To outline what action local, state and federal authorities should take to ensure the area specific strategies are fully implemented and stop transmission.
- To outline actions that partners including WHO, Unicef and other GPEI stake holders should take at the sub-national, national and international level to support the area specific strategies

### **Advisory Committee on Poliomyelitis Eradication**

The fifth meeting of the Advisory Committee on Poliomyelitis Eradication (ACPE) was convened in Geneva, Switzerland, on 18–19 November 2008. The meeting concluded that

*Nigeria poses a high risk to international health until new political commitment is translated into field-level improvements in campaign quality (>30% of children remain unvaccinated in Kano).*

### **World Health Assembly**

The World Health Assembly adopted the following resolution on 24 May 2008 on polio:

[The World Health Assembly] urges Nigeria to reduce the risk of international spread of poliovirus by quickly stopping the outbreak in northern Nigeria through intensified eradication activities

### ***Major Milestones in Polio Eradication in Nigeria***

- 1996: First Polio Eradication SIAs conducted
- 1997: AFP Surveillance initiated
- October 2003: Suspension of polio campaigns in Kano, Kaduna and Zamfara states due to unfounded rumours about OPV safety
- December 2003: Resumption of polio campaigns in Kaduna and Zamfara states
- July 2004: Resumption of polio campaigns in Kano
- Feb 2006: mOPV1 piloted in 4 states in Nigeria

- May 2006: mOPV1 used in large scale sub-national campaign in all endemic states
- May 2006: Immunization Plus Days (IPDs)
- July 2006: First confirmed cVDPV in Nigeria
- July 2007: First use of mOPV3 in Nigeria

### ***Nigeria Polio Evaluation Team***

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- Prof Ghazi Jamjoom Virologist (Chair, National Polio Eradication Committee), Jeddah, Saudi Arabia
- Ms Jane Nyanzi, Health Communication Specialist, Kampala Uganda
- Dr Robert Hall, Epidemiologist (Chair, WPRO Technical Advisory Group), Melbourne, Australia
- Prof Idris Mohammed, Public Health Specialist (national team member), Gombe, Nigeria

### **Technical support**

- Dr Roland Sutter, Coordinator, Research & Product Development, Polio Eradication, WHO, Geneva
- Mr Thomas Moran, Technical Officer, Polio Eradication, WHO, Geneva

### ***Schedule of Visits and Activities***

- Abuja 4 – 6 August 2009
- Sub-team 1: Kano 7 – 11 August 2009
- Sub-team 2: Zamfara 7 – 11 August 2009
- Abuja 12 – 14 August

### ***Activities***

The Evaluation Team commenced with a review of available literature relating to the polio eradication initiative in Nigeria, other policy documents through which the initiative is executed, and also the study of the World Health Organization partnership frameworks.

They had an intense programme of meetings and discussions with officials, decision-makers and other stakeholders at federal, state and local government levels. The team met and held discussions with

- the Honourable Federal Minister of Health,
- the Honourable Federal Minister of State for Health,

- Commissioner for Health of the States of Kano and Deputy Governor of the state of Zamfara, ( Our team met Dy Governor as commissioner was not available)
- Permanent Secretaries for Health of the States of Kano and Zamfara,
- officials from the Office of the Millenium Development Goals,
- Councilors for Health at several Local Governments,
- polio eradication programme staff at the three levels,
- the executive Director of the National Primary Health care development agency, and
- Project coordinator of ECHITAB Study group.

The Team also met and had valuable discussions with representatives of His Eminence the Emir of Kano, and with leaders of religious and traditional institutions in Kano and Zamfara.

In addition, valuable meetings were held with a number of partners from other agencies involved with the polio eradication programme, including staff from WHO, Unicef, the European Union, the German Government, the Japanese International Cooperation Agency, the Centers for Disease Control and Prevention and many others. Discussions at the meetings with the various partners centered around the additional efforts that were required to increase coverage of polio vaccine.

The sub-teams visited a wide range of health facilities in the States of Kano and Zamfara, including hospitals, rural and urban health centers, State and Local Government vaccine stores cold stores, etc. During these visits, the teams observed both routine and supplementary immunization activities. The team also reviewed coverage and surveillance data obtained from the WHO office in Abuja and Gusau in Zamfara State.

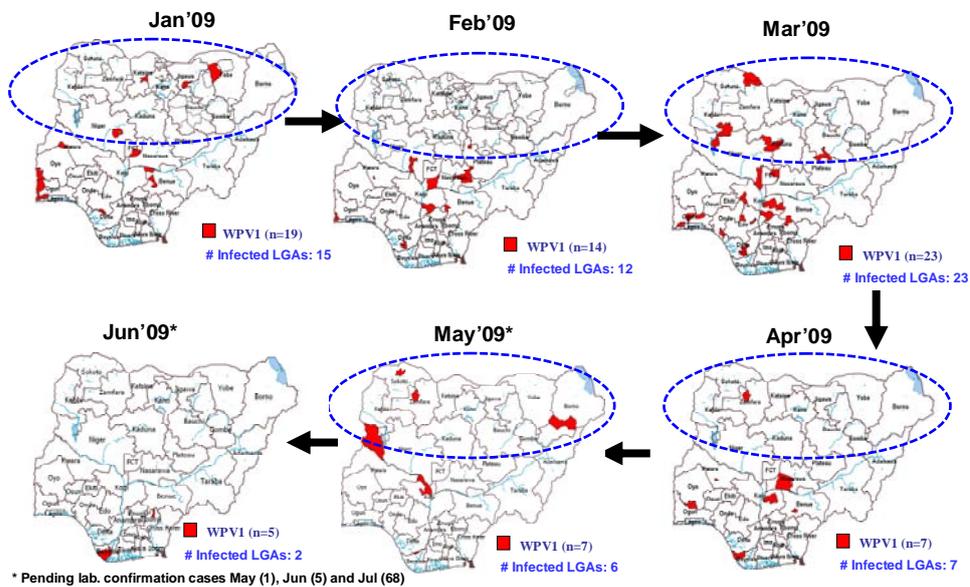
### ***Epidemiological situation***

#### **Surveillance**

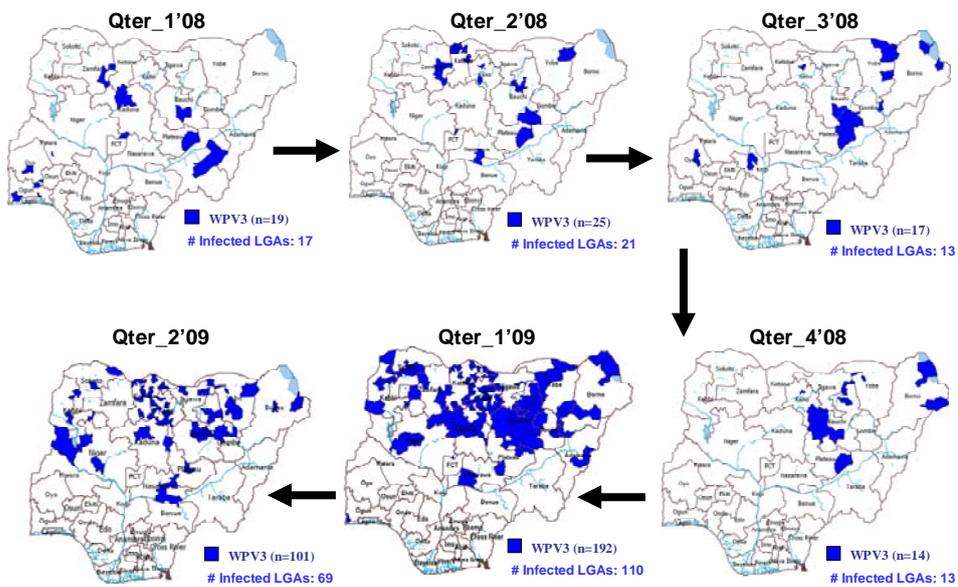
#### **AFP reporting**

Though the entire country met the AFP surveillance criteria indicating good surveillance practices, discussion with some clinicians indicated that they report suspected cases, but often do not receive the results of laboratory testing.

**Monthly distribution of WPV1 infected LGAs in high risk states (in circle) in last 6 months, January – June 2009**



**Distribution of WPV3 infected LGAs by quarter 2008 - 09**



### ***Reported immunization coverage***

There have been 6 immunization plus days (IPDs) in 2009, consisting of

- a national mOPV3 round (January-February)
- a sub-national mOPV1 round (February-March)
- a national mOPV1 round (March)
- a national tOPV round (May-June)
- a sub-national mOPV1 round (July)
- a national tOPV round (August)

A further sub national round is planned for October. The states of Kano and Zamfara were included in all of these rounds.

Coverage reported, on the basis of house monitoring data, ranged between 92% and 94% for each round, with between 27.7 million and 49.7 million children receiving vaccinations.

There was considerable variation between Local Governments, with between 10% and 38% not reaching 90% coverage during the SIPD rounds. Similarly, at the ward level, between 19% and 30% of wards did not reach a coverage of 90%. Overall, this has left about 2 million children unvaccinated during the IPD rounds. Of these, over 600,000 unvaccinated children are in the Northwestern states, which have the highest incidence of polio cases.

Reasons for remaining unvaccinated include

- house not visited; 7% to 16% of unvaccinated children
- child absent; 50% to 61% of unvaccinated children
- non-compliance; 25% to 39% of unvaccinated children

The data on coverage in SIAs appear to be inconsistent with the data on surveillance. With the level of coverage reported during the IPDs one would expect to see far fewer reported cases of wild polio and paralysis due to circulating vaccine- derived polioviruses (cVDPVs).

The team considered that analysis of surveillance and coverage data is often inadequate. The team did not observe much analysis at the Local Government and Ward level. Such analysis would have been useful in microplanning for IPDs. For example, Talata Mafara was cited as a low risk Local Government Area, but monitoring data indicated very poor coverage, with house-to-house monitoring showing a coverage of only 78.3% and monitoring in public areas showing a coverage of only 66%.

In 2008, 74% of all WPV cases occurred in children less than 3 years old; and in 2009, 67% of WPV cases were aged less than 3 years. This indicates that a large number of very young children do not have effective immunity, most likely due to not receiving vaccine, or due to ineffective vaccine. The team observed several deficiencies in the cold chain (see Appendix 1).

The Evaluation Team heard reports on routine EPI delivery. A project, “Strengthening Routine Immunization in Kano” (SRIK) has been operating in Kano for a year and a half and some results are available. Essentially, the routine immunization programme is very

weak. The SRIK project found 69% dropout for DTP3 and a coverage for fully-immunized children of only 5.5%. It is clear from these results that the routine immunization programme cannot be relied upon to achieve high levels of poliovaccine coverage and the polio eradication programme is entirely dependent on the quality of its own achievements. However, the polio eradication initiative can be used to strengthen the routine programme, and this will be critical in the maintenance phase of polio eradication, after interruption of wild poliovirus transmission. This low level contrasts with the claimed coverage derived from official administrative data. Support for ongoing efforts to improve Routine Immunization performance through the Reaching Every Ward (REW) approach was found grossly inadequate in the state and LGAs visited.

The Evaluation Team did not observe any strong resistance to immunization, although some parents did complain of discourteous behaviour on the part of vaccinators in some places.

### ***Abuja Declaration***

The Evaluation Team considers that the Declaration of Abuja, signed by Prof Babatunde Oshotimehin, Honorable Minister of Health on behalf of the Federal Government and His Excellency Dr Bukola Saraki, Executive Governor of Kwara State and Chairman of the Governors' Forum on behalf of all the Governors' in February 2009 signaled the start of a renewed effort for polio eradication in Nigeria. Since then, there has been greatly increased commitment to the programme at the highest levels. This has resulted in considerable progress with an increase in polio immunization coverage and has resulted in a reduction in AFP cases.

The Abuja Declaration recognizes the requirement for universal polio immunization coverage for Nigerians in order to achieve the goal of polio eradication. It further declares the Governments' view that oral polio vaccine is a safe and effective vaccine eminently suited for Nigerian children. The Declaration reaffirms the Governments' determination to eradicate polio from Nigeria as soon as possible and show strong leadership to all sectors of Nigerian society in support of this aim.

The Evaluation Team considered that the commitments made in the Abuja Declaration have resulted in increases in programme performance during recent SIAs (March-August 2009).

This agreement, between the national and state levels, has led to greater commitment and support to polio eradication.

The Evaluation Team considered that, though after signing of the Abuja Declaration there has been increasing adherence by State and LGA leaders to the agreements espoused in the declaration which has impacted positively on the quality of polio eradication activities in the country especially in the polio endemic states and LGAs (acknowledged by independent experts and the ERC), more government oversight is needed to improve the weak immunization services. In Zamfara the Evaluation Team observed that 2 of 14 Local Governments had not established their Polio Elimination Task Forces and one task force had not started operations. One senior official at Gusao was not aware of the Abuja Declaration. Though all Local Governments released their counterpart funding (ranging from N100,000 to N950,000) these amounts appear inadequate to achieve sustained community participation and social mobilisation. The Federal Government may consider issuing directives and guidelines to States and Local Governments to provide adequate funds according to the size of the target population,

in order to achieve and maintain uniform and adequate immunization and social mobilization activities

### ***The Role of the Federal Government***

The National Government has the overall leadership and coordination role for polio eradication in Nigeria. In collaboration with international partners and agencies, the National Government has led the development of the Abuja Declaration, and with it much came of the recent progress.

The Federal Government is in a position to assist and encourage States and Local Government to renewed efforts to finish the job. And though the Federal government has placed a lot of effort on polio eradication despite a very broad health development agenda, it is felt that the Polio Eradication would benefit from even more support at the Federal level, especially as polio eradication will need to be given increased attention as we progress towards zero transmission. A possible mechanism may be the use of a focal point in the Federal Government, with the authority of the President and Government, to ensure that progress continues to be made at all levels. It would be helpful to establish similar focal points at State and Local Government levels. Such focal points would clarify lines of responsibility, improve implementation and establish clearer accountability. Task Forces should provide overall technical and administrative support to the focal point. During discussions with several Task Force members it appeared that the capacity of the Task Forces to undertake incisive analysis of the current situation is inadequate. Efforts are need to enhance their capacities particularly at the Local Government and State levels.

To ensure that commitment and oversight is translated into improved quality of implementation of key program activities, the Evaluation Team considered the value of enhancing the accountability and political stake of the partners in the polio eradication programme by ensuring close monitoring and follow up of polio eradication activities at high level, including by the President's and Governors' Offices. The Evaluation Team considered a number of suggestions to address road blocks in the way of polio eradication, including the addition of polio eradication as a regular agenda item in discussions between the President and State Governors and subsequently with the Local Government Chairpersons.

### ***The Role of Donors***

A large numbers of donors are assisting in Polio Eradication Initiative. The role of the donor and partners in supporting the National Polio Eradication effort in in Nigeria is clearly laid out in the ICC governance structure, which was last reviewed in 2004 and may need to be updated. All partners and donors are members of the different committees and working groups according to their areas of competence. The 2009 immunization operational plan was adopted in Gusau, Zamfara state at an ICC meeting chaired by the Honourable Minister of Health and attended by all partners and Donors on the ICC.

Discussions with several donor organizations indicated that there is not a coherent strategic plan specifically for polio Eradication although there is a comprehensive Multi year immunization plan for 2009-2014( developed with the support of all the partners and donors)

The mechanisms for developing such a strategic plan for Polio Eradication with the support of the partners and donors are laid out in the ICC structure. Involvement of donor partners in monitoring and analysis through a strategic framework of programme implementation and accountability to the suggested focal points at the Presidential and Governor and Local government levels could be considered.

Donor partners should be involved in monitoring and analysis to ensure achievement of results and accountability.

### ***The Role of the States***

States provide much of the immunization infrastructure. States have major roles to play in vaccine logistics and cold chain management. The State vaccine stores visited in Kano appeared adequate for current purposes, but this was not the case in Zamfara. The planned upgrades should ensure that the vaccine stores at all the places are adequate.

State Governments also play a major role in leadership. There are two key components to this:

- leadership in programme management, and
- leadership in social mobilization.

In the recent past, there have been issues with community perceptions of the safety of polio vaccines, to the extent that OPV was withdrawn from use in the State of Kano in 2003-2004. The issues with the vaccine were couched in religious terms and in this community, as in other areas, this may have depressed community demand to a very great extent. These religious concerns have created major barriers to implementation of polio eradication, which persists today. However, political, religious and traditional leaders are now very supportive of polio immunization and an enthusiastic programme of social mobilization should overcome these barriers.

The Evaluation Team was impressed by the commitment of the Commissioners for Health and their staffs for the programmes. The Evaluation Team was especially gratified to hear of the strong support for polio eradication from the traditional institutions and the level of knowledge of the issues of polio eradication. The Evaluation Team considers that this level of support, if sustained, should overcome most of the existing barriers.

The Evaluation Team held discussions with officials from other instrumentalities of State Government, including civil servants from Departments of Local Government and Education. There are many issues to secure the wholehearted engagement of these agencies, including competing demands and levels of resources, but the Evaluation Team considered that these agencies will play a critical role in the achievement of polio eradication. The education sector, in particular, was keen to play a prominent role in social mobilization, using the schools as major vehicles for building and reinforcing community demand for polio eradication.

The Evaluation Team considered that the accountability of the polio eradication programme could be enhanced through monitoring and follow up of activities carried out by Local Government and State Governors. The Evaluation Team considered that polio eradication could be a standing agenda item in regular meetings between the State Governors and Local Government Chairpersons. The Team considered that this would increase the political commitment and support at Local Government levels.

### ***The Role of Local Government***

The “war” against polio in Nigeria will be won or lost at the local government level. Immunization delivery takes place at this level, and it is the face of the polio eradication programme to the public. Local Government is in the ideal position for this task, being the instrument of state that is closest to the people and is able to respond most effectively to the needs of the community.

There is great variability in Local Government. In the State of Kano there are 44 Local Governments and 14 in Zamfara. The Evaluation Team heard that in some areas the programme was well supported, but in others interest, support and supervision were weak. In some Local Governments, funds for polio immunization activities were released very late, sometimes only 24 hours before the start of activities which left inadequate time for preparation and mobilization of resources and the community. The Evaluation Team was informed that the performance of polio eradication activities was highly dependent on the commitment of the Local Government Chairpersons, and the priority they placed on polio eradication. Local Government Chairpersons should make polio eradication activities a high priority.

The physical infrastructure for the programme appeared to the Evaluation Team to be basically sound, with more than adequate Health facilities, cold stores, transport and the like. Maintenance of the cold chain was observed to be problematical. A key example was the non-functioning of solar refrigerators; many had no batteries, often because the refrigerators had been worked beyond their design, being used to make large quantities of ice-bricks, a purpose for which they were not designed.

Funding of polio eradication activities was variable. Often funds were not available or were available very late, such that the detailed planning required for SIAs could not be effectively carried out. A longer-term funding solution will need to be found. The Evaluation Team was informed of innovative potential solutions such as the concept of “basket funds” as used in Zamfara.

However, the Evaluation Team considered that, despite the quality of the basic infrastructure, there were very significant issues with maintenance, consumables and other materials. The polio eradication programme has a very detailed operational manual, which provides excellent guidance on all aspects of the programme. Yet, the Evaluation Team considered that polio staff were not able to carry out all its precepts because small or large impediments were placed in the way. Often critical supplies were missing, and team supervisors were not able to rectify these problems.

Performance management was weak in all areas visited. The Evaluation Team considered this to be vital. Local Government performance could be evaluated on a continuing basis with several methods including

- checklists that cover essential components of the programme
- methods used in lot quality studies.

The Evaluation Team considered that the quality of mid-level and lower-level (at the level of community activities) management to be very significant barriers to the achievement of polio eradication in Nigeria.

The large numbers of children missed by the routine immunization programme and the Polio Eradication Initiative were grim reminders of the seriousness of these barriers. The State of Zamfara state recently introduced street teams to find and cover missed children, but this initiative did not yield the desired result. Reasons given were that the scheme was

very new was not well understood. However, a more focused strategy to reach out to missing children and to reach the hard-to-reach should be considered important barrier and addressed.

### ***Social Mobilization and the Role of Community-Based Organizations***

Community-based organizations are critical to the success of polio eradication, in ensuring a well-informed community demanding high-quality immunization services. Inadequate mobilization of such groups, such as women's groups and others, is a key barrier to community demand. Inadequate community interest, support, and demand have therefore become barriers to polio eradication. The Evaluation Team was informed that community demand for polio and routine immunizations was not strong, since there had been doubts expressed by political and religious leaders some years ago. Polio has not been the highest priority in terms of child survival and there is a disjunction between immunization and other health care services. The Evaluation Team was told of instances where mothers were skeptical about the free availability of polio vaccine, and the requirement to purchase treatment for malaria, for example.

The vaccination teams were equally poorly equipped with the appropriate interpersonal communication skills to respond to even the slightest community challenges met during IPDs. Such skills should be a basic requirement for immunization team members, especially in areas of low coverage. It may be necessary to establish training programmes for staff to ensure that all teams are adequately prepared.

The late release of funds to support social mobilization activities is a major issue. Late release of funds seriously compromises the quality of social mobilization activities implemented prior to each round of immunization.

Addressing these issues will require the cooperation of many sectors of society, but particularly partners supporting social mobilization activities, community women organizations, religious and traditional leaders.

Some innovative social mobilization projects have been established which appear to have resulted in good results. These projects should be examined for lessons and applied more broadly.

The essence of social mobilization is ownership by and partnership with the community. Results from Polio Eradication activities will be greatly improved through such an approach and avoidance of any suggestion of compulsion. Funding could be targeted to building participatory approaches.

### ***Programme Management***

The Evaluation Team considered that management issues which occur at all levels were the most critical barriers to the success of the Nigerian programme. At high level, the recent increase in commitment has to be translated into action that supports staff in the middle levels and, most importantly, on the ground. At the lower level, Local Government Chairpersons must show leadership in timely mobilization and release of funds to the programme. They should also show their commitment to the programme with effective leadership of Local Government Task Forces and management of their health staff. Although the Evaluation Team was scheduled to meet Chairpersons from 8 Local Governments, they were only able to meet 3.

This is shown very clearly in the performance of Immunization Plus Days. Performance is variable and critically dependent on Local Government, and particularly the

Chairperson's, commitment.

### ***Financing***

Financing the polio eradication programme is a critical area. Although The Evaluation Team did not find areas where major injections of funds were needed, the Team did consider that local funding was sometimes difficult, especially for some Local Governments struggling with the priority given to polio eradication, in addition to their other responsibilities. There appeared to be major problems with the management of funds. Often funds were released very late, sometimes as late as 24 hours before the start of SIAs. This had the effect that planning was largely ineffective, and that the considerable resource mobilization required did not occur. As a consequence performance in the SIAs in those areas was very weak and accountability for the use of funds was a major issue. Very many respondents raised concerns over funds mismanagement and lack of accountability for funds. If verified, this may constitute a serious barrier to effective implementation of the Polio Eradication Programme. Weak accountability and non-receipt of updated financial expenditure statements are contributing to a major barrier like emerging polio-fatigue amongst policy makers, stakeholders and communities and inadequate and late arrival of operational funds.

All stakeholders at all levels should embrace good accountability practices. Communities should also be encouraged to demand immunization services

### ***Conclusions***

The Evaluation Team was impressed by the progress that has been made in polio eradication in Nigeria in the last year or so. After meeting with key officials at various levels of the Federal, State, and Local governments and Emirs, the Evaluation Team feels assured that political, religious, and traditional leaders are now very supportive of the immunization campaign and that previous concerns or misconceptions based on unfounded rumours about polio vaccine safety appear to have been largely corrected or only maintain a negligible influence.

This was an important and encouraging finding of our visit. It came as a result of such efforts as the Abuja Declaration and advocacy campaigns by the Federal, State, and Local governments and international partners

However, the Evaluation Team considered that there was much work remaining to be done, since with the current programme performance, polio eradication will not be achieved in Nigeria.

The Evaluation team concluded that the major challenges for Polio eradication in Nigeria are:

- Translation of the increased commitment into programme effectiveness at all levels. This is largely a matter of management commitment, skill and commitment. It depends on high quality personnel, logistics and financial management and strong political leadership.
- Establishment of dedicated leadership positions for polio eradication at Federal, State and Local government levels. These leaders would put the decisions and recommendations of government and Task Forces into practice.
- Good programme management and oversight, particularly at the Local Government level
- Sub-optimal OPV coverage at NIDs.

- Further strengthening of surveillance systems in order not to miss any chains of transmission. The Evaluation Team was satisfied that Nigeria has a functioning AFP surveillance system capable of detecting most chains of poliovirus transmission, and that this is presently not a barrier to polio eradication. However, with further progress towards elimination, the requirements for surveillance become more stringent, and further strengthening of surveillance and response will be necessary.
- Creation, strengthening and maintenance of community interest in immunization and demand for polio eradication.

### ***Recommendations***

As the basic infrastructure in Kano and Zamfara was found to be sound the Evaluation Team considered that by

- Sustained Government commitment at all levels,
- Defining the mandate, responsibilities, objectives, and accountability of key leaders at various levels of government committed to eradication,
- Accelerating activities,
- Good operational financial and logistical programme management, especially for NIDs,
- Good public communication and social mobilization,
- Further strengthening the existing surveillance system, and
- The involvement of all strategic partners, including the community and women's groups etc

Polio eradication is feasible in Nigeria in the near future.

### ***Acknowledgements and thanks***

The Evaluation Team wishes to thank the following for their assistance and hospitality

- The Federal, State and Local Governments of Nigeria
- People who discussed the issues with the Team
- Leaders of the traditional and religious institutions
- Partner agencies such as Unicef and others
- Staff assigned to assist the evaluation

The Evaluation Team is thankful for and acknowledges the hospitality of Nigeria and the frank and open discussions on the work remaining to be done in Nigeria to interrupt poliovirus transmission.

## Appendix 1

State vaccine store at Zamfara:

- Target population for polio vaccine 716,582
- 147 wards
- 110 solar refrigerators; 54 not functioning
- Solar refrigerators inadequate
- 3 weeks break down of back up generator last year. Presently two back up generators; one is 40 years old needs replacement. Vaccines used: OPV, BCG, DPT, HBV, yellow fever, measles, TT
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- OPV: Total vaccine received during campaign: 1,022,900 doses; total released 1,000,126 doses
- Shortage of vaccines in January 2008
- Routine programme requirement 122,900 doses
- Out of 19 deep freezers 9 functioning; vaccine security consultant advised replacement of non-functioning deep freezers but no action yet
- Inadequate freezing capacity: resulting in inadequate supply of ice packs during the campaign. Inadequate supply of ice packs.
- Ice lined refrigerators: of 18, only 12 functioning, 6 require replacement
- Each LGA has one or two deep freezers
- No LGA is without a deep freezer
- Cold chain capacity at the ward level inadequate
- 92/147 wards without functioning solar refrigerators
- Transport capacity for vaccine is inadequate due to inadequate funds for fuel
- The State cold store standby generator not functioning well and therefore cannot be used as back up for frozen ice packs production

## Appendix 2

### ROAD MAP FOR IMPLEMENTATIONS OF RECOMMENDATIONS IN NIGERIA

The following provides suggested performance-based and goal-driven roadmap, with clear phases, timelines, target dates, and benchmarks:

#### To address Health System and Service Delivery barriers:

- Establish immediately a dedicated polio focal point with appropriate administrative and financial authority at the Federal health Ministry, State Health Ministry and at LGA level to strengthen the existing administrative structure and carry forward polio eradication activities on a mission mode giving a timeline of 18-24 months to achieve zero-transmission from the date of assuming charge. Apart from Govt. providing requisite administrative support at respective levels, major donor agencies should similarly provide necessary technical support in planning, monitoring, analyzing and periodic reviewing. Timeline: Federal and state Govt. level during 1<sup>st</sup> month and at LGA level by the end 3<sup>rd</sup> month.

**Benchmark:** Functioning polio focal point at Federal and state Govt. level = first month; Priority LGAs= 2<sup>nd</sup> month; All LGAs =3<sup>rd</sup> month

- Establishing a polio cell ( monitoring focal point ) at the presidency directly overseeing the polio eradication activities with regard to release of funds, involvement of various stake holders ( religious leaders, indigenous rulers, donors, women groups, non-health sector players etc ), program of reaching the missed un-reached children, expenditure statement etc. Similar such focal points needs to be established at Governor's office and Chairman's office at the LGA level They should be directly connected through hot-lines: Timeline : during First 2 months.

**Benchmark:** Functioning monitoring focal point at the presidency, and state Governor. level = 2<sup>nd</sup> t month; Priority LGAs= 3<sup>rd</sup> month; All LGAs = 4<sup>th</sup> to 6 months

- Immediate review of the current framework of involvement of donors and put in place a revised coherent strategic plan and updated mechanism specifying role of all donors at the federal, state and LGA level linking them appropriately to various stake holders at federal , state and LGA level. Timeline: During the First 2 months

**Benchmark:** A revised coherent strategic plan and updated mechanism specifying specific role of each and every donor in place = 2<sup>nd</sup> month

- The routine immunization programme was found to be very weak. Fortunately vast RI infrastructure is available. What is needed is their appropriate involvement not only in RI but also in campaign through capacity building and additional funding. A large number of children attend RI institutions. Those opportunities should not be missed in providing polio drops. The recommendations made by Expert Review Committee on Polio Eradication and Routine immunization in Nigeria in their 16<sup>th</sup> meeting in October 2008and 17<sup>th</sup>

meeting in April 2009, should be fully implemented. Time line: First 6 months

**Benchmark :** ERC recommendations to strengthen RI fully implemented by 6<sup>th</sup> month; RI infrastructure is suitably involved in campaign

**To address Community barriers**

- Review National integrated communication and social mobilization strategy to remove hindrances to its implementation and rigorously implement the same with wider involvement women's group, religious leaders, indigenous rulers so that program management can reach out to the missed children and difficult areas and community demand is generated for polio immunization. Time lines: First 6 months
- Review the innovative social mobilization projects which gave good results. Lessons learnt could be examined and applied more broadly. Time line : First 3 months

**Benchmark:** Review completed and applied accordingly 3-6 months

**To address Non-health sector barriers**

Inadequacy of funds, Mismanagement of funds, and Lack of adequate involvement of other sectors like education need to be taken care of through proper federal directives

- The Federal Government should consider providing additional funds at the State and LGA level and issuing directives and guidelines to States and Local Governments to provide adequate funds according to the size of the target population, in order to achieve and maintain uniform and adequate immunization and social mobilization activities. Simultaneously all stakeholders at all levels should embrace good accountability practices and funds must be released in time and accounted for: Time line: 1<sup>st</sup> two months.

**Benchmark:** Additional funds available at LGA level to sustain continued support of the community, religious leaders and indigenous rulers by the end of 2<sup>nd</sup> month

**To address Technical barriers**

- Develop a more focused strategy to reach out to missing children and to reach the hard-to-reach should be considered important barrier and addressed. Time line : First 3 months
- Monitoring and analysis checklists should cover essential components of the programme'. Consider methods used in lot quality studies. Time line : First 3 months

**Benchmark:** As campaigns are held within a short interval, fast track analysis of campaign data should be undertaken to provide feed back for the next campaign.

# **Independent Evaluation Team of Barriers to Polio Eradication in Nigeria**

# Overview

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- Objective
- Team composition
- Schedule of visits & activities
- Strengths & weaknesses
- Assessment
- Critical barriers to be removed to achieve eradication in Nigeria

# Objective of Review

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- At the request of the Director General of the World Health Organization, the evaluation team is to identify the critical barriers that prevent polio eradication in Nigeria

# Team Composition

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- Members:
  - Dr Ali Jaffer Mohammed, Director General of Health Services (Chair, EMRO Technical Advisory Group), Muscat, Oman
  - Dr Kamal K Datta, Public Health expert (former Director of National Institute for Communicable Diseases), Kalkota, India
  - Prof Ghazia Jamjoun, Virologist (Chair, National Polio Eradication Committee), Riyadh, Saudi Arabia
  - Dr Jane Magoba-Nyanzi, Expert in Communication, Kampala, Uganda
  - Prof Robert Hall, Epidemiologist (Chair, WPRO Technical Advisory Group), Melbourne, Australia
  - Prof Idris Mohammed, Public Health Specialist (national team member), Gombe, Nigeria
- Technical support:
  - Dr Roland Sutter, Coordinator, Research & Product Development, Polio Eradication, WHO/Geneva
  - Mr Thomas Moran, Technical Officer, Polio Eradication, WHO/Geneva

# Schedule of Visits / Activities

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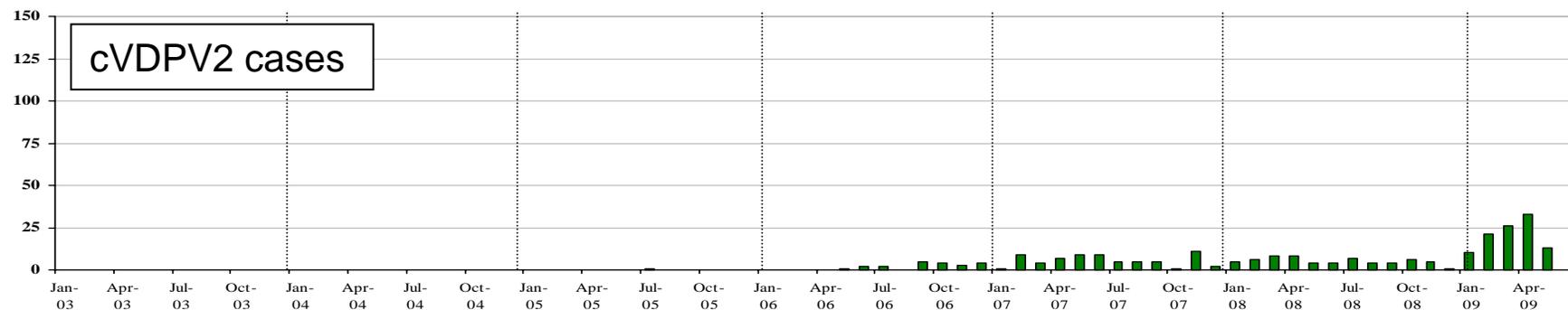
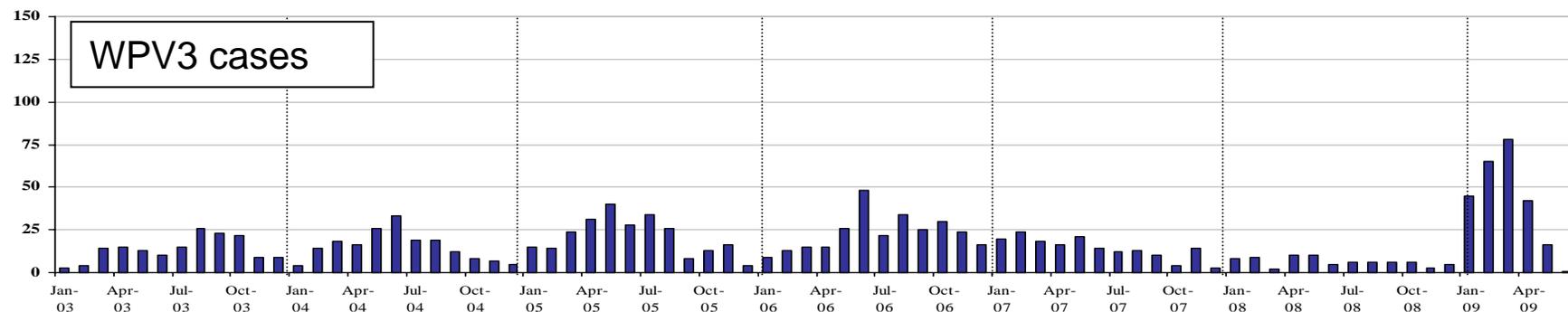
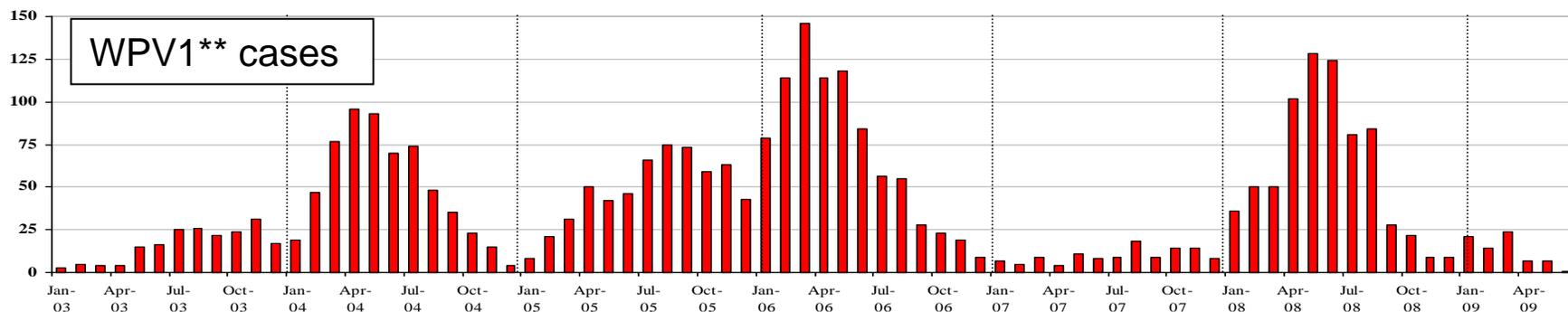
- Schedule of visits:
  - Abuja: 4-6 August 2009
  - Sub-team 1: Kano: 7-11 August 2009
  - Sub-team 2: Zamfara: 7-11 August 2009
  - Abuja: 12-15 August 2009
- Activities
  - Discussions & formal meeting with decision-makers, partner and stakeholders at national, provincial, and national levels
  - Visits to LGAs, health facilities, cold stores, etc.
  - Observation of field activities (SIAs)
  - Review of desk data (surveillance, reports)

# Situation Analysis

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- Nigeria only country in the world with co-circulation of wild type 1 poliovirus, vaccine-derived type 2 poliovirus, and wild type 3 poliovirus
- The only reason for this is that many children are not vaccinated during SIAs and routine immunization activities

# 2003-2009\* monthly distribution of wild poliovirus and cVDPV2 cases in Nigeria



\*Data in WHO/HQ as of 30 Jun 2009

\*\*includes 3 cases in 2004, 3 in 2005, 2 in 2006, 1 in 2008 and 2 in 2009 with mixture of W1/W3 virus

# Strengths and Weaknesses I

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- **Strengths**

- Declaration of Abuja in February 2009 & establishment of task team of traditional leaders by HE Sultan of Sokoto resulted in greatly increased commitment to finish polio eradication
  - Commitment is evident at the highest national & state levels from political, traditional & religious leaders
  - And has resulted in program performance improvements (lower zero-dose children) during in recent SIAs
- Existing infrastructure and systems to deliver OPV to the target population
- Functioning AFP surveillance system detecting most chains of poliovirus transmission

# Strengths and Weaknesses II

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- **Weaknesses**

- SIAs performance is variable and greatly dependent on LGA commitment & resources
- Data of SIAs coverage and polio epidemiology are conflicting
- Community demand for SIAs polio drops & routine vaccination in general is weak
- Social mobilization is inadequate
- Routine vaccination is almost non-existing (i.e., Kano) and thus cannot be relied upon to achieve eradication

# Team Assessment

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- The war against polio in Nigeria will be won at the LGA level
- But with current quality of polio program activities, polio eradication cannot be achieved in Nigeria
- In order to achieve eradication within the next 12 months, the review team has identified three critical barriers:
  - Increase commitment & establish direct program oversight
  - Overcome LGA weaknesses
  - Create demand for immunization at grass-roots levels

# Critical Barriers to Eradication I

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- Increased commitment and oversight needs to be translated into improved quality of key program activities:
  - the political stake as well as accountability needs to be enhanced by ensuring close monitoring and follow-up of PEI by HE President and Governors' office (i.e., establishing a small unit within the respective offices)
  - implementation of all aspects of the Abuja declaration closely monitored including regular PEI progress reports from Governors to HE President
  - regular reports from LGA chairs to Executive Governors (and feed-back meetings)

# Critical Barriers to Eradication II

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- LGA performance in SIAs is variable and highly-dependent on LGA leadership. LGA release of funds for SIAs activities may be late or not forthcoming (because of lack of funds and many competing activities)
  - Find a longer-term SIAs funding solution for LGA (i.e., basket account implemented in Zamfara)
  - Monitor LGA performance with a checklist that can then be shared with Governor for feed-back meeting with LGA chairs
  - Improve the quality of monitoring data (through use of additional methods such as Lot Quality Sample (LQS))

# Critical Barriers to Eradication III

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- The community demand for polio and also routine vaccination at the grass-roots levels is weak.
  - Greatly enhance community mobilization activities for polio and routine immunization (ward by ward)
  - Follow-up with day-to-day mobilization of grassroots organization, such FOMWAN, etc.
  - Involve other sectors, especially schools, with education packages to educate teachers and students
  - Involve religious & traditional leaders at the village and ward levels with information on polio eradication (share commitment of higher level leaders)
  - Share Haj and Umra vaccination requirements broadly

# Strengthening Routine Immunization

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- Routine immunization is a key strategy for polio eradication
- Building on polio eradication successes, the governments mid-term to long-term goals to revitalize and strengthen Routine Immunization and Primary Health Care are important elements to support the immediate and short-term goals of polio eradication and sustain eradication for the longterm

# Final Conclusions

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- The strongest and the weakest link of the polio eradication program in Nigeria is the LGA level
- If the critical barriers to success will be removed, polio eradication is feasible within a 12-month period span in Nigeria

The Evaluation Team would like to express their deep gratitude for the cooperation, education, assistance, and hospitality.