VACCINATION PROGRAMME IN NIGERIA AND UNENDING VACCINE PREVENTABLE DISEASES

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OUTLINE

- INTRODUCTION
- BENEFITS OF IMMUNIZATION
- CHALLENCES
- STRATEGIES TO ADDRESS CHALLENGES

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INTRODUCTION

- Immunization is **a public health strategy and programme for improving child survival to** combat key diseases that kill children but also provide a platform for other health services.

- This term is often used interchangeably with **vaccination or inoculation.**
- Immunisation is the process of both getting the vaccine and becoming immune to the disease after vaccination.
- Vaccination is the term used for getting a vaccine — that is, actually having the injection or taking an oral vaccine dose.

EXPANDED PROGRAMME ON IMMUNIZATION (EPI)

- The Expanded Programme on Immunization (EPI), introduced in 1978 with the aim of providing routine immunization to children less than the age of two years, recorded initial but intermittent successes.
  - Polio, Measles, Diptheria, Pertussis, Tuberculosis. Yellow Fever

- The optimum level recorded by the early 1990s -81.5%.
- But since that period of success, Nigeria has witnessed gradual but consistent reduction in immunization coverage.
- By 1996, the national data showed less than 30% coverage for all antigens, and this decreased to 12.9% 2003 and among the lowest in the world and explains the poor health status of children in the country.
- It is the worst in the west African subregion, only better than Sierra Leone.

- 1985-1995-EPI Aimed to strengthen immunization, accelerate disease control and introduce new vaccines and relevant health technologies and tools
- 1995-Nigeria adopted the WHA resolution and UN General assembly special goals to achieve by 2005
  - Polio eradication
  - Measles mortality reduction
  - Maternal and Neonaternal tetanus elimination

- 1998- Nigeria laid core objectives of EPI
  - Monitoring performance, quality and safe immunization
  - Assessment of current and future VPDs-sicknesses, death, disability, economic burden
  - Impact of vaccination strategies, epidemiological surveillance, reliable lab confirmation
- 2005-Ratify UN General Assembly Session to achieve by 2010
  - Adequate immunizationfor <1 year-90% national coverage and 80% in every state
  - Eliminate Vit A deficiency

- 1996-Recorded < 30% coverage
- 2003-Recorded 12.9%
- 2000-Nigeria adopted the MDG to reduce childhood mortality by 2/3rd in 2015
  - NPI replaced EPI and suffered setbacks due to religion, ethnicity and propaganda
- Immunization coverage varies dramatically across Nigeria. All states fall below the global goal of 90% coverage.

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Trend of Routine Immunization Coverage in Nigeria, 2011 - 2021

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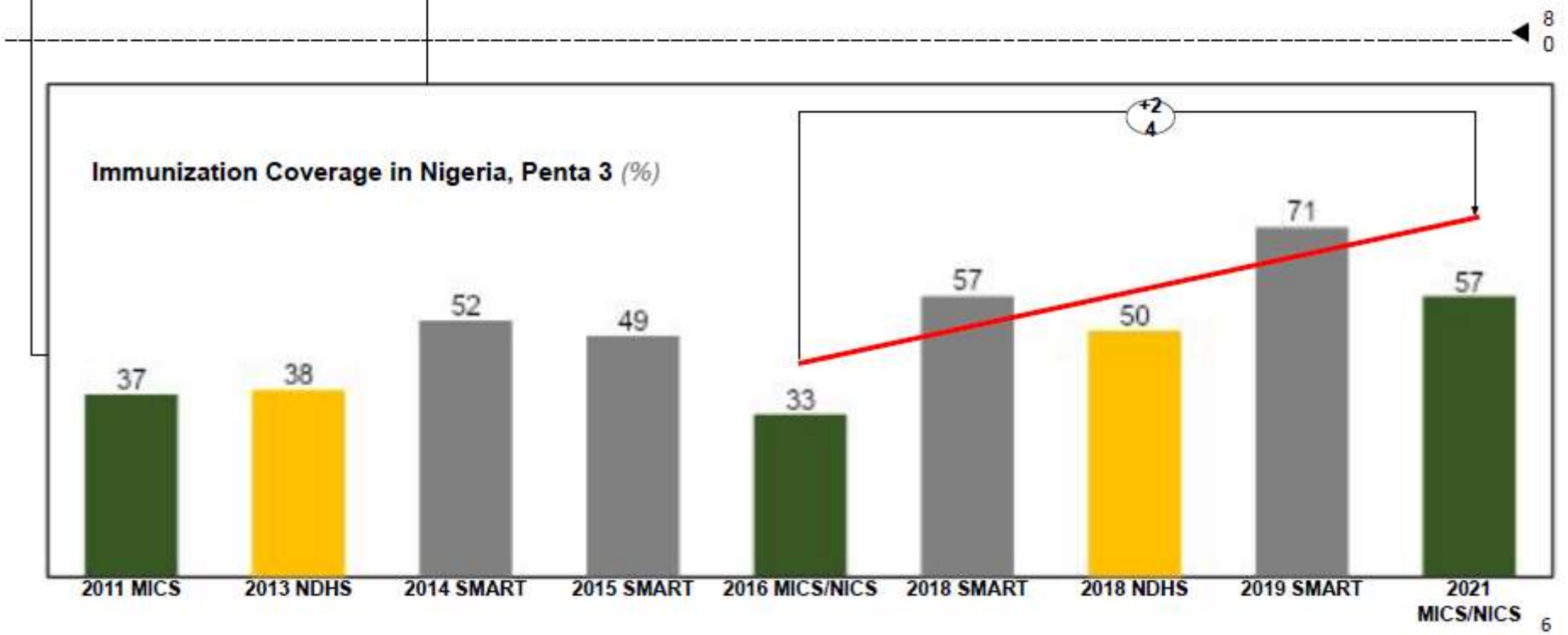

Source: NPHCDA

Routine Immunisation Schedule

Minimum target age of child	Type of vaccine	Dosage	Route of administration	Site	Diseases prevented
At birth	BCG	0.05ml	Intra dermal	left upper arm	Tuberculosis, polio, Hepatitis B
	OPV 0	2 drops	Oral	Mouth	
	Hep B0 birth	0.5ml	Intramuscular	Anterolateral aspect of right thigh	
6 weeks	Pentavalent (DPT,Hep B and HiB)1	0.5ml	Intramuscular	Anterolateral aspect of left thigh	(Diptheria+Pertussis +Tetanus+Hepatitis)
	Pneumococcal Conjugate Vaccine 1	0.5ml	Intramuscular	Anterolateral aspect of right thigh	pneumonia and meningitis.
	OPV 1	2 drops	oral	Mouth	polio
	IPV 1	0.5ml	Intramuscular	Anterolateral aspect of right thigh (2.5cm apart from PCV)	polio
	Rotavirus vaccine 1	5 drops	oral	Mouth	Diarrhea
10 weeks	Pentavalent (DPT,Hep B and HiB) 2	0.5ml	Intramuscular	Anterolateral aspect of left thigh	(Diptheria+Pertussis +Tetanus+Hepatitis)
	Pneumococcal Conjugate Vaccine 2	0.5ml	Intramuscular	Anterolateral aspect of right thigh	pneumonia and meningitis.
	OPV2	2 drops	Oral	Mouth	polio
	Rotavirus vaccine 2	5 drops	Oral	Mouth	diarrhea,
14 weeks	Pentavalent (DPT,Hep B and HiB) 3	0.5ml	Intramuscular	Anterolateral aspect of left thigh	(Diptheria+Pertussis +Tetanus+Hepatitis)
	Pneumococcal Conjugate Vaccine 3	0.5ml	Intramuscular	Anterolateral aspect of right thigh	pneumonia and meningitis.
	OPV 3	2 drops	Oral	Mouth	polio
	Rotavirus vaccine 3	5 drops	Oral	Mouth	diarrhea,
	IPV 2	0.5ml	Intramuscular	Anterolateral aspect of right thigh (2.5cm apart from PCV)	Polio
5 months	Malaria Vaccine	0.5ml	Intramuscular	Anterolateral aspect of right thigh	Malaria
6 months	Vitamin A 1st dose	100000 IU	Oral	Mouth	Nutritional supplement
	Malaria Vaccine	0.5ml	Intramuscular	Anterolateral aspect of right thigh	Malaria
7 months	Malaria Vaccine	0.5ml	Intramuscular	Anterolateral aspect of right thigh	Malaria
9 months	Measles 1st dose (MCV1)	0.5ml	Subcutaneous	Left upper arm	measles
	Yellow fever	0.5ml	Subcutaneous	Right upper arm	Yellow fever
	Meningitis Vaccine	0.5ml	Intra Muscular	Anterolateral aspect of left thigh	Meningitis
	Vitamin A 2nd dose	200,000 IU	Oral	Mouth	Nutritional supplement
15 months	Measles 2nd dose (MCV 2)	0.5ml	Subcutaneous	left upper arm	Measles
	Malaria Vaccine	0.5ml	Intramuscular	Anterolateral aspect of right thigh	Malaria
9 years	HPV	0.5ml	Intramuscular	Deltoid muscle (left upper arm)	Human papiloma virus

* HPV Vaccine for all 9 year old girls

MR has replaced MCV

NEW VACCINES

- Pentavalent vaccine (DPT, HB, HiB)-started around 2014
  - 6 weeks
  - 10 weeks
  - 14 weeks
- IPV-
  - 6 weeks –started > 2 years ago
  - 14weeks- started last year
- Rotavirus-started end of last year
  - 6 weeks
  - 10 weeks
- MEN A- started last year- Ag based vaccine
  - 9 months
- HPV
- Malaria
- Measles Rubella

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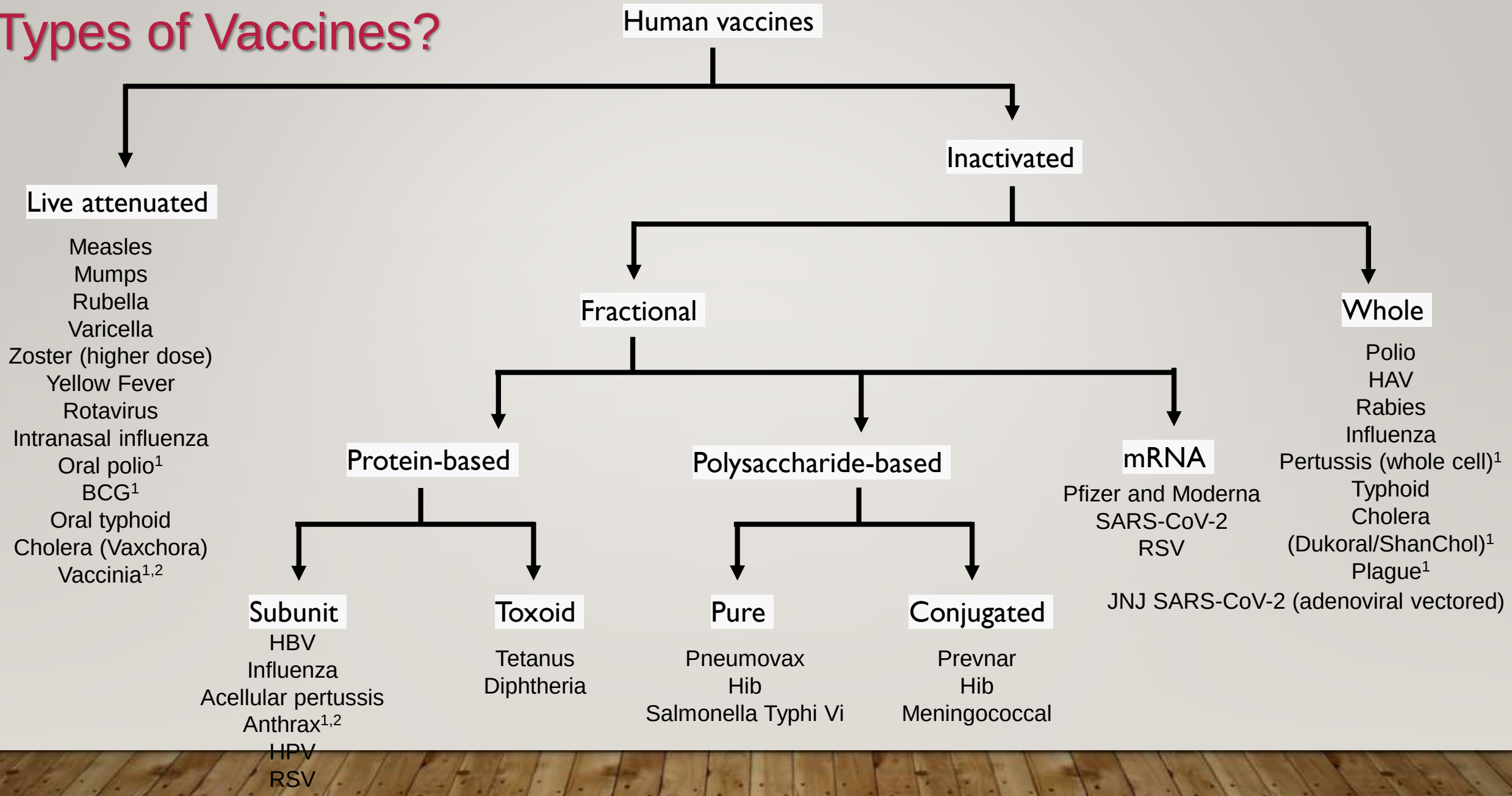
Types of Vaccines?



[1] Not routinely given in U.S. [2] Available under IND from CDC

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Benefits of Immunization

- Reduced morbidity
- Reduced mortality- saves 4.4 million lives yearly
- Increased life expectancy
- Reduced disability
- Improved educational attainment
- Reduction in school days lost
- Reduction in loss of productivity
- Prevents antimicrobial resistance
- Return on investment

Benefits of Immunization

- Prevents the spread of infectious diseases.
- Reduces the risk of serious illness and complications.
- Protects vulnerable populations, such as infants, elderly, and those with weakened immune systems.
- Contributes to herd immunity, making it harder for diseases to spread within communities.
- Saves lives by preventing numerous deadly diseases.
- Lowers healthcare costs by reducing the burden of treating preventable diseases.
- Supports public health efforts to control and eliminate certain diseases.
- Increases overall community and global health and well-being.

LIST OF PRELIMINARY IMMUNIZATION STAKEHOLDERS IN NIGERIA

- **National Primary Health Care Development Board (NPHCDA)-**Government
- **State Primary Health Care Development Agencies (SPHCDA)-**Government
- **National Emergency Routine Immunization Coordination Centre (NERICC)-**Government
- **World Bank-**Funder
- **Gavi-**Funder
- **Bill and Melinda Gates Foundation-**Funder
- **United Nations International Children's Emergency Fund (UNICEF)-**Funder/Technical Assistance
- **United States Agency for International Development (USAID)-** Funder/Technical Assistance
- **World Health Organization (WHO))-** Funder/Technical Assistance
- **Rotary International)-** Funder/Technical Assistance
- **Clinton Health Access Initiative (CHAI))-** Funder/Technical Assistance
- **MOMENTUM Routine Immunization Transformation and Equity (MRITE)-** Technical Assistance

LIST OF PRELIMINARY IMMUNIZATION STAKEHOLDERS IN NIGERIA

- **Global Polio Eradication Initiative (GPEI)-** Technical Assistance
- **Syndani-** Technical Assistance
- **Save the Children-** Technical Assistance
- **The Africa Field Epidemiology Network (AFENET)-** Research and Implementation
- **Solina Centre for International Development and Research-** Research and Implementation
- **The Christian Health Association of Nigeria-** Research and Implementation
- **London School of Hygiene & Tropical Medicine (LSHTM)-** Research and Implementation
- **Global Health Advocacy Incubator-** Technical Assistance/ Advocacy

Reasons for not vaccinating

1. **Systemic** – Vaccines not available/affordable

- Vaccinator not available
- Not screening for vaccination status
- Vaccinating only on some days
- Not opening a multidose vial when
- Children who came for vaccination are few
- Negative attitude of health care workers
- Poor tracking

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Reasons for not vaccinating

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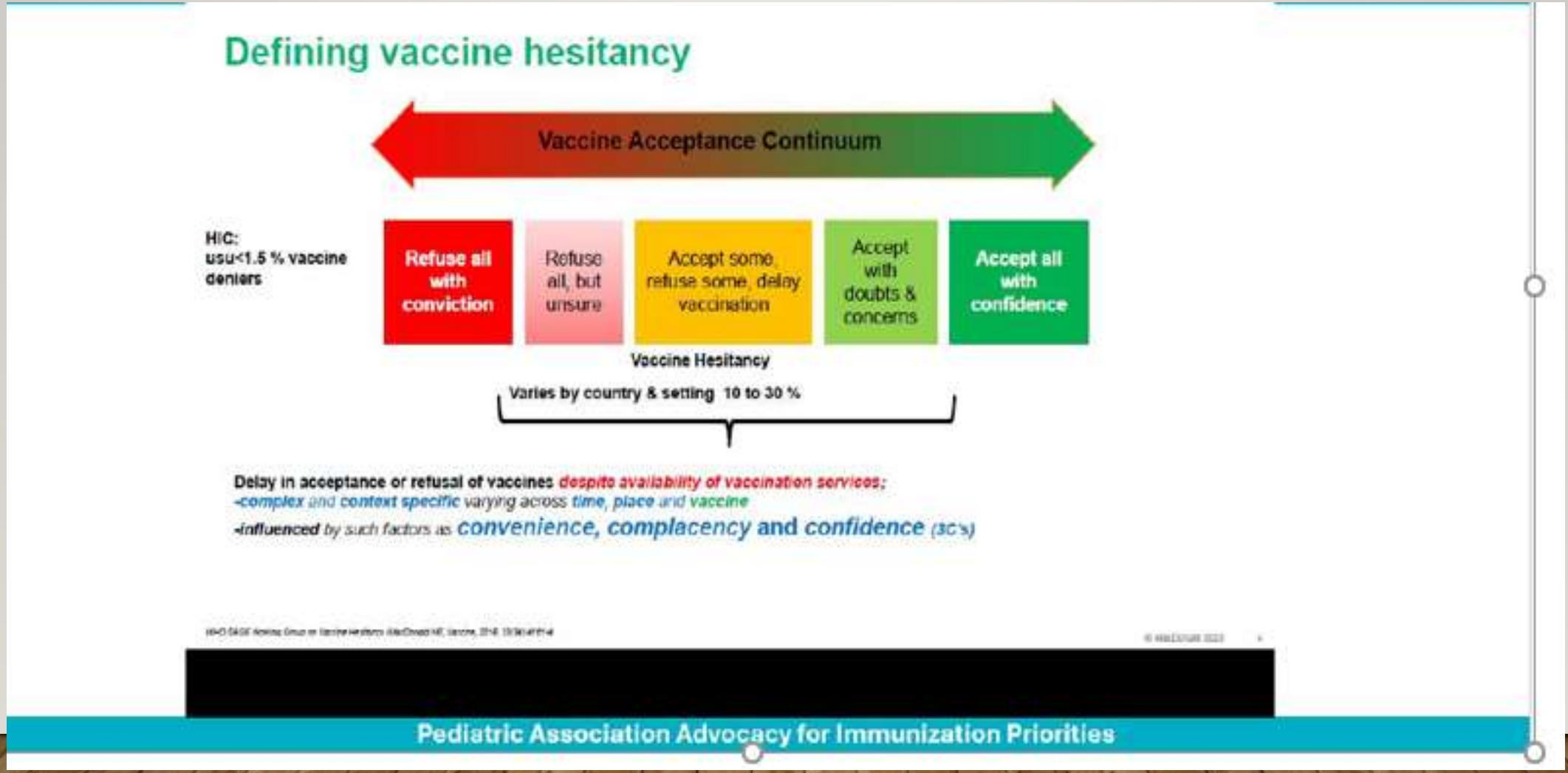
2. Individual-level- Lack of information- place, date and need to come back

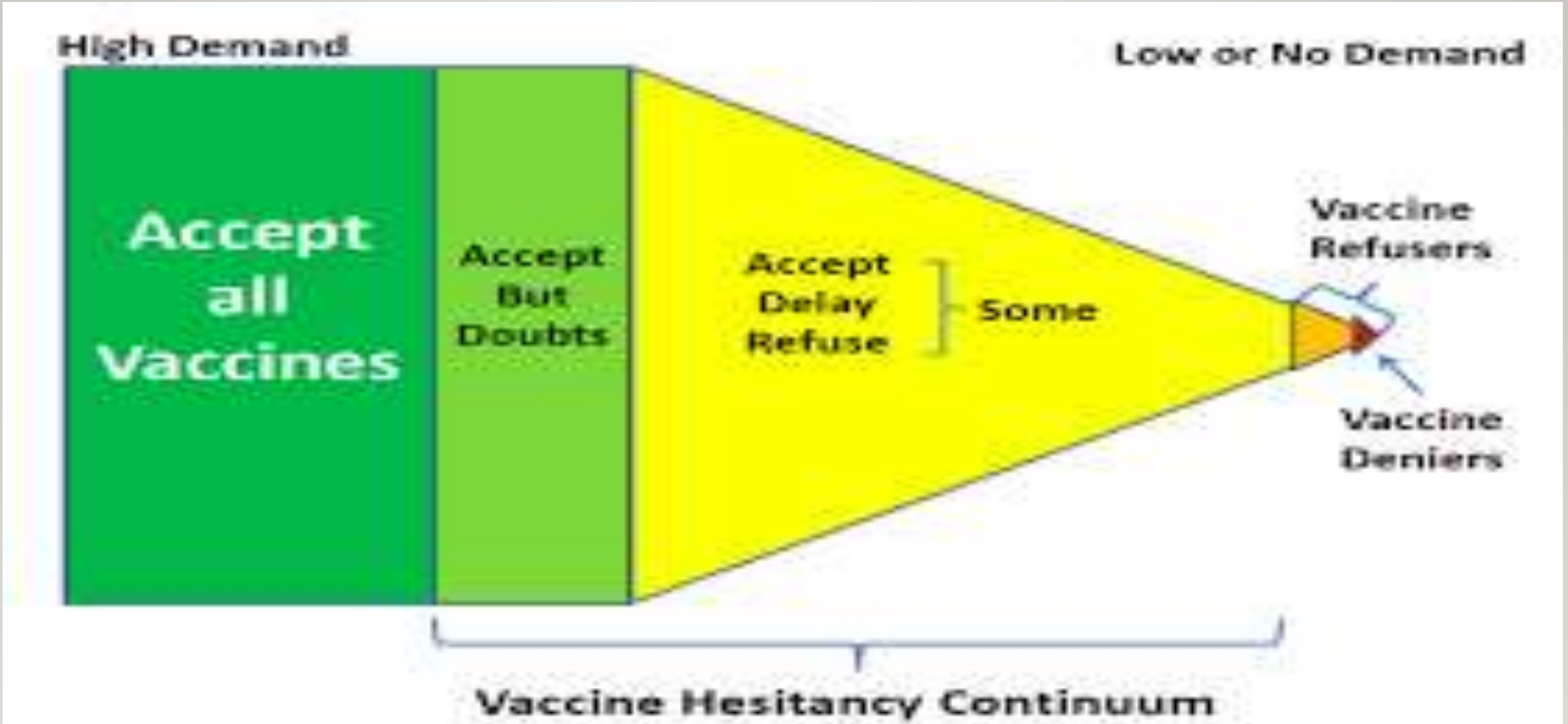
- Lack of motivation
- Obstacles- fear of side effects, caregiver illness, HF too far, transportation costs, insecurity, long waiting times
- Rumours, myths, misinformation and disinformation

FACTORS AFFECTING VACCINATION-HCWS

- Lack of Confidence
- Misinformation
- Fear of SES
- Knowledge gap
- Personal beliefs and values
- Workplace behaviours

VACCINE HESITANCY




High Demand
Low or No Demand
Accept all Vaccines
Accept But Doubts
Accept Delay Refuse
Some
Vaccine Refusers
Vaccine Deniers
Vaccine Hesitancy Continuum

IMPACT OF VACCINE HESITANCY

- Poor vaccination coverage
- Persistence of disease
- Reduction in herd immunity
- Poor disease control with losses in morbidity, mortality, disability and health spending
- Threaten economies especially when there is an outbreak/epidemic
- Threatens national/international security

Who are the ZERO-DOSE CHILDREN?

- Children who have not received any basic routine immunization
- For operational purpose, Zero-dose children defined as children who have not received a single dose of diphtheria, tetanus and pertussis-containing vaccine
- They are usually untraceable and not trackable by governments
  - Most live nomadic lifestyle
  - Displaced children by conflict, and natural disasters which have increased due to climate change
  - Poverty: Majority live in poor households (surviving on less than US$ 1.90 per day)
  - Displaced because of food insecurity
  - Some unreachable because of gender-based systematic exclusion

https://www.gavi.org/vaccineswork/zero-dose-child-explained?gad_source=1&gclid=[illegible]

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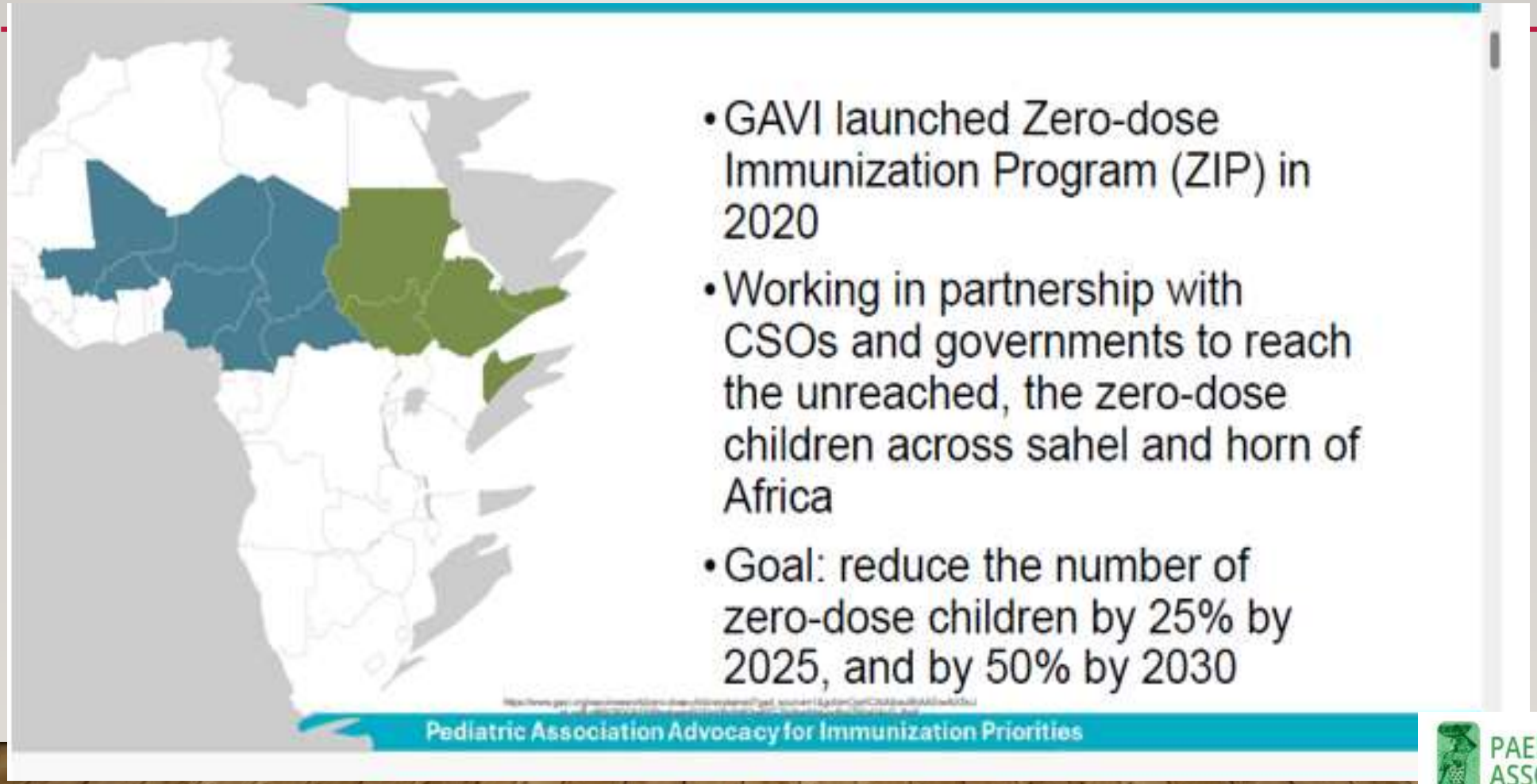
- In Nigeria and for the purposes of this landscape, ZD children are defined as those who have not received a single dose of the Penta vaccine series.

ZIP



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Why the focus on Zero-Dose children?

- About 50% of children that die from vaccine preventable diseases are zero dose children
- Closing the gap in Immunisation inequity: 1 in eight children still not receiving a single dose of vaccine in LICs
  - 2 out of 3 zero-dose children live in households below the poverty line
  - Locating zero dose children is a track to locating other healthcare inequities
  - 49 % less likely to have a mother who received antenatal care
  - 49% less likely to have a mothers who had an institutional delivery
  - 38.8% less likely to live in a household with water and cleansing agents

Gavi internal analysis based on WHO estimates of cause of under-5 deaths, vaccine co-coverage from DHS/MICs and WUENIC coverage data

Locations of most Zero-dose children

Nearly 50% of zero-dose children live in three key geographic areas: urban areas, remote communities and populations in conflict settings

https://www.gavi.org/vaccineswork/zero-dose-child-explained

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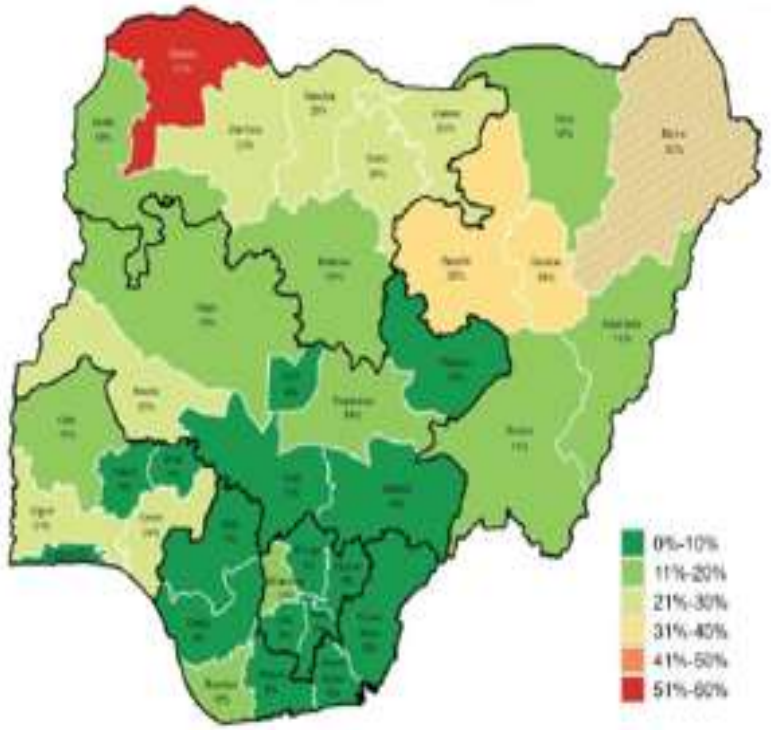
ZERO DOSE CHILDREN IN NIGERIA

- Nigeria contributes 25% to the burden of Zero-dose children in GAVI sponsored countries, the second largest in the world
- UNICEF estimate that 18% of children under 2 years have never received vaccine - 2.2m using 2021 WUENIC data estimate
- The largest in West Africa with total estimate of unvaccinated children 4.8m
- All 774 LGAs have Zero dose children
- However, the majority is in the Northern States
- Out of the 100 LGAs prioritized by government for intervention to reduce zero dose children, 90 are in the Northern states



2022 WHO/UNICEF Estimates of National Immunization Coverage (WUENIC)

Pediatric Association Advocacy for Immunization Priorities

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LIST OF 100 PRIORITIZED LGAS

BAUCHI	ALKALERI	GOMBE	YAMALTU/DEBA	KANO	KUMBOTSO	PLATEAU	QUA'AN PAN
BAUCHI	BAUCHI	JIGAWA	BIRINIWA	KANO	NASSARAWA	PLATEAU	SHENDAM
BAUCHI	DARAZO	JIGAWA	BUJI	KANO	SUMAILA	PLATEAU	WASE
BAUCHI	GAMAWA	JIGAWA	DUTSE	KANO	TAKAI	SOKOTO	BODINGA
BAUCHI	GANJUWA	JIGAWA	GWARAM	KANO	TARAUNI	SOKOTO	DANGE-SHUNI
BAUCHI	GIADE	JIGAWA	KAFIN HAUSA	KANO	TUDUN WADA	SOKOTO	GADA
BAUCHI	ITAS/GADAU	JIGAWA	KIYAWA	KANO	UNGONGO	SOKOTO	GORONYO
BAUCHI	KATAGUM	KADUNA	BIRNIN GWARI	KATSINA	BATAGARAWA	SOKOTO	GWADABAWA
BAUCHI	MISAU	KADUNA	GIWA	KATSINA	BAURE	SOKOTO	KWARE
BAUCHI	NINGI	KADUNA	IGABI	KATSINA	FUNTUA	SOKOTO	RABAH
BAUCHI	SHIRA	KADUNA	IKARA	KATSINA	KANKARA	SOKOTO	SABON BIRNI
BAUCHI	TORO	KADUNA	KUBAN	KATSINA	KATSINA	SOKOTO	SHAGARI
BAUCHI	ZAKI	KADUNA	LERE	KATSINA	MANI	SOKOTO	SOKOTO SOUTH
BORNO	DAMBOA	KADUNA	MAKARFI	KATSINA	RIMI	SOKOTO	TAMBUWAL
BORNO	GUBIO	KADUNA	SABON GARI	KATSINA	SAFANA	SOKOTO	WAMAKO
BORNO	JERE	KADUNA	SOBA	KEBBI	BAGUDO	SOKOTO	WURNO
BORNO	KONDUGA	KADUNA	ZARIA	KEBBI	BIRNIN KEBBI	TARABA	GASSOL
BORNO	MAFA	KANO	BEBEJI	KEBBI	GWANDU	YOBE	GEIDAM
BORNO	MAIDUGURI	KANO	DAMBATTA	LAGOS	ALIMOSHO	YOBE	GULANI
BORNO	MONGUNO	KANO	DAWAKIN KUDU	LAGOS	IKORODU	ZAMFARA	BUNGUDU
BORNO	NGALA	KANO	DAWAKIN TOFA	NASARAWA	LAFIA	ZAMFARA	GUMMI
FCT	MUNICIPAL AREA C	KANO	GABASAWA	NASARAWA	NASARAWA	ZAMFARA	GUSAU
GOMBE	DUKKU	KANO	GAYA	NIGER	MASHEGU	ZAMFARA	KAURA NAMODA
GOMBE	FUNAKAYE	KANO	GEZAWA	ONDO	ILAJE	ZAMFARA	MARU
GOMBE	KWAMI	KANO	KIRU	PLATEAU	KANAM	ZAMFARA	TALATA MAFARA

Pediatric Association Advocacy for Immunization Priorities

Source: NPHCDA – National Primary Health Care Development Agency

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Strategies to reach zero-dose children

AVAILABILITY OF SERVICE - ADDRESS SUPPLY BARRIERS-

VACCINE CONFIDENCE, SERVICE UPTAKE

EFFECTIVE PARTNERSHIPS

Challenges reaching the unreached children with vaccination

- GOVERNANCE
- Public awareness and acceptability
- Program management

Governance

- Political leadership change
- Unstable awareness of the scope and seriousness of the target diseases
- Unstable political will and varied prioritization of immunization programs
- Lack of understanding of the economic gains of optimal immunization program
- Competing health and non-health programs for prioritization
- Security challenges are both competing priorities and major impediment to efforts at reaching zero dose children

GOVERNANCE/POLICIES

Immunization Financing

- In 2022, Nigeria spent approximately $177.5 million on routine immunization, including vaccines, of which 55 percent was financed by the government and 45 percent by external funders

Table 3. National Policy and Strategy Documents Relevant to Immunization

Policy/Legislation	Year/s	Summary
Nigeria Strategy for Immunisation and PHC System Strengthening (NSIPSS)	2018–2028	The government's 10-year plan to improve and sustain immunization coverage and strengthen PHC service delivery. It also includes Nigeria's plan to transition the financial ownership of the immunization and PHC system in line with its graduation from Gavi support. The plan also establishes immunization objectives, including increasing the national coverage of Penta3 to 84 percent, and strategies for system improvement ranging from leadership and accountability to data systems.
Nigeria Strategy for Immunisation and PHC System Strengthening Version 2.0 (NSIPSS 2.0)	2021–2024	The NSIPSS 2.0 is a companion document to the 2018–2028 NSIPSS that provides a short-term, three-year roadmap for reducing the number of ZD children and optimizing RI in Nigeria based on the first three years of 2018–2028 NSIPSS implementation and shifts in the local and global immunization agenda, particularly following the COVID-19 pandemic. It presents a new target of at least 90 percent coverage for all antigens in the country 2024, as well as updated objectives related to key health

Challenges in the Program

- INEFFECTIVE PROGRAM IMPLEMENTATION DUE TO WEAK PROGRAM LEADERSHIP
- LOGISTICAL CHALLENGES: INFRASTRUCTURAL CHALLENGES, UNSTABLE ELECTRICITY SUPPLY, DIFFICULT TRANSPORTATION TERRAINS
- INSUFFICIENT SKILLS FOR VACCINE STORAGE AND HANDLING
- INADEQUATE MANAGEMENT OF INFORMATION SYSTEM
- INSUFFICIENT MONITORING AND EVALUATION OF PROGRAM IMPACT
- FUNDING GAPS
- POOR FUNDING COORDINATION AND LINKAGES BETWEEN NATIONAL AND SUBNATIONAL MANAGEMENT OF IMMUNIZATION PROGRAM

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Public ownership of Immunisation program

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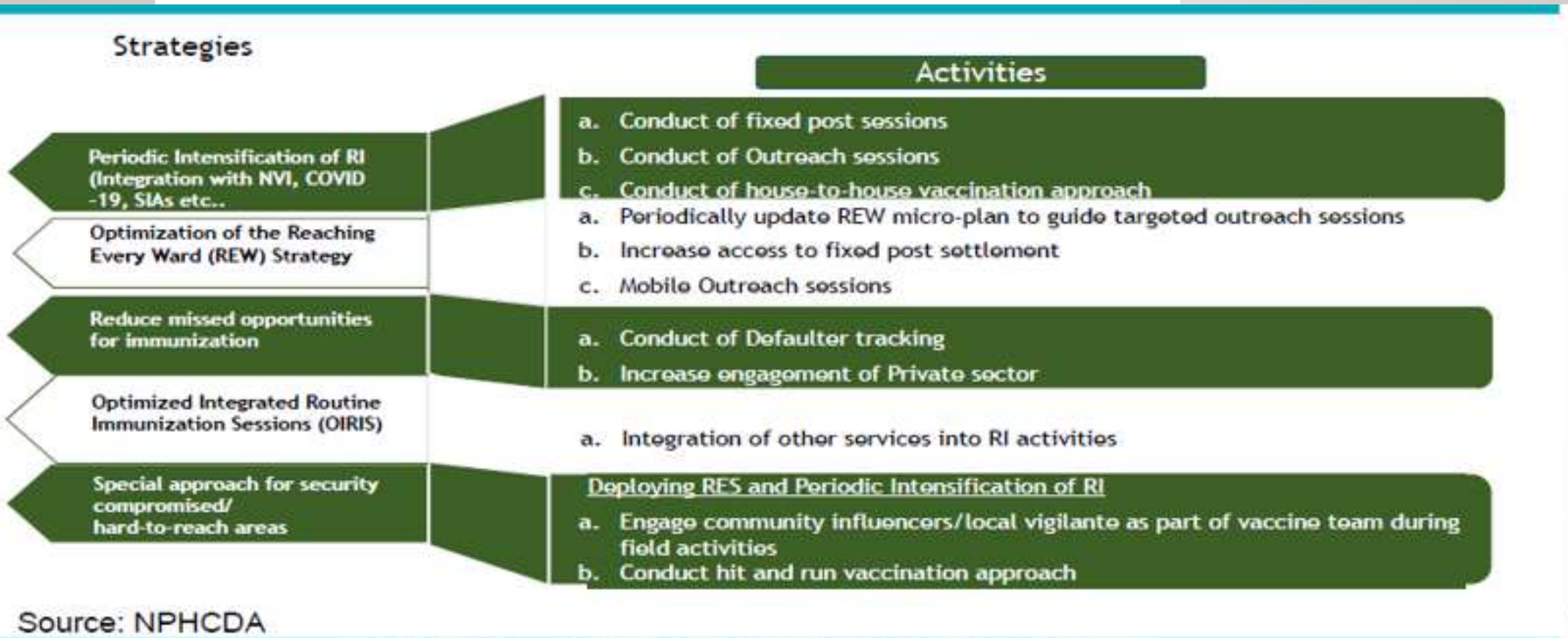
- Lack of public knowledge
- Limited access to primary health care facilities
- Low public awareness and understanding of the scope and seriousness of the target diseases
- Vaccination hesitancy
- Lack of public demand for immunization program
- Insufficient community ownership and demand for accountability in immunization program

Several strategies have been developed and deployed to reach zero-dose children at subnational level



Source: NPHCDA

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NEWLY INTRODUCED VACCINES

- Pneumococcal Conjugate Vaccine-2014 and 2016
- Inactivated Polio Vaccine (IPV)-2015 (1st dose) & 2021(2nd dose)
- Rotavirus Vaccine- 22nd August 2022
- Human Papilloma Virus Vaccine-24th October, 2023 (Phase1) and days-27th May-2 June, 2024 (Phase2)
- Malaria vaccine-
- Measles Rubella –Vaccine October, 2025 (Phase1) and January and February 2026 (Phase2)

HPV VACCINE

- Locations of vaccination:
  - Fixed Post-Hospitals
  - Mobile sessions-schools, communities (markets, IDPs, churches,mosques)
  - Outreaches, Mop-ups
- **Phase 2 in 21 states**-2024 campaign-Intensification period (5 days-27th May-2 June, 2024) then continued
- **Phase 3-Routinize into RI schedule from 2025 but only for girls 9 years old**
- SEs-Pain, swelling, redness, very rare fainting

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HPV VACCINE

- Gardasil 4 (Strains 6, 11, **16** & **18)**-6,11-Warts and 16,18-Cervical cancer and other cancers (Vulva, anal, throat, Penile)
- Multiage cohort (MAC)-Girls 9-14years old
- Phases1 , 2 and 3
- HPV causes > 95% of Cervical cancer
- **Recombinant vaccine**
- Single dose IM
  - **BUT 2 doses for HIV positive eligible girls at 6-12months after the first dose**
  - **No contraindication with any Co-morbidity-SCD, Cardiac, Renal etc**
- Left Deltoid muscle
- Cold chain +2 to 8^{o}C

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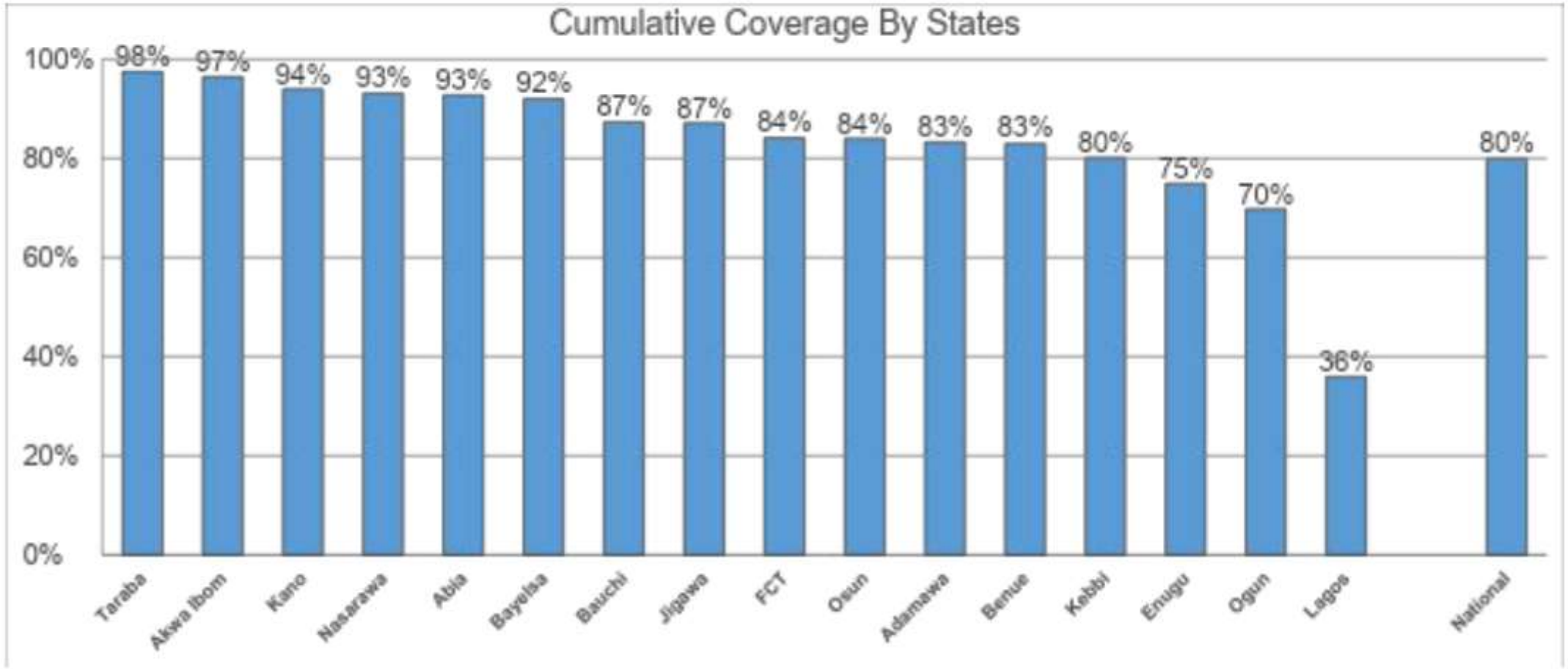
HPV Vaccination Rate Using MULTI AGE COHORT (MAC) Campaign Targets (80% of TP). Data as at Jan 29th



4.9 million adolescent girls were vaccinated during the MAC Campaign across 15 phase 1 states and the FCT

Source: Daily Call-In Data

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Nigeria introduced the HPV vaccine in October 2023 through MAC campaigns to girls aged 9 to 14 in 16 phase I states

Some Key Wins are:

Total Girls vaccinated

4,952,897 (MAC)

% in-School vaccinated

43.6%

% out of school vaccinated

56.4%

No. Vaccinated by Fixed

1,004,961

No. Vaccinated in Outreach

3,947,936

Results from the HPV MAC campaign revealed the following:

- Achievement of 80% of national target coverage for HPV vaccination.
- The campaign and mop up activities achieved 80% of the MAC target for 9-14-year-olds target population.
- 4,952,897 adolescent girls aged 9-14 years were vaccinated during the HPV Introduction MAC campaign across the 16 phase 1 states
- The country has commenced plans for phase 2 HPV introduction

Data source: HPV Coverage - Daily call-in data (Accessed on 6th February 2023)

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We need to shift gears from building confidence to generating demand as vaccine supply increases

Vaccine Confidence

Promoting the belief that vaccines work, are safe, and are part of a trustworthy medical system.

Demand Generation

Mobilizing individuals and communities to seek, support and advocate for vaccines.

Courtesy: Dr Walter Oreinstein

STRATEGIES TO INCREASE VACCINE CONFIDENCE AND COVERAGE

1. Educational Campaigns:

1. Use informational posters, letters, and educational materials to highlight disease risks and emphasize the importance of vaccination.
2. Provide personalized education about vaccines.
3. Conduct group educational sessions to raise awareness.
4. Implement decision aids to guide individuals through the vaccination decision-making process.
5. Consider health risk appraisals to assess health behaviors and preventive care uptake.
6. Use TV and media to promote disease awareness and vaccine efficacy for specific populations.

2. Institutional Recommendations:

1. Encourage vaccination within institutions and workplaces.
2. Provide vaccination stickers to promote a positive social norm around vaccination.

STRATEGIES TO INCREASE VACCINE CONFIDENCE AND COVERAGE

1. **On-Site Vaccination**:
    1. Increase convenient access to vaccines by offering vaccination on-site or at workplaces.
    2. Make vaccines accessible near hospital/clinic entrances, work sites, and high-traffic areas.
    3. Consider mobile carts and extended hours (including nights and weekends) for vaccination.
    4. Offer home vaccination options.
2. **Free or Affordable Vaccines**
3. **Vaccine Ambassadors**
4. **Medical Provider Standardization**
    1. Ensure consistent vaccine recommendations from healthcare providers.
    2. Standardize vaccine messaging to build trust and confidence among patients.

MISINFORMATION

- **Misinformation** in the context of childhood routine immunization refers to **false or inaccurate information** that circulates about vaccines and vaccination programs.
- It can lead to misconceptions, doubts, and hesitancy among parents and caregivers regarding vaccinating their children.
- Misinformation →safety, efficacy, or alleged harmful effects that are not supported by scientific evidence.

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DEFINITION OF TERMS

- **Misconception**: Refers to **incorrect beliefs** based on faulty information.
- **Myth**: Refers to **traditional stories** that explain cultural beliefs or customs.
- Understanding these differences helps us avoid perpetuating false beliefs and ensures clarity in communication.
- **Disinformation**:
  - **Disinformation** is **deliberately false or misleading information** that is **spread with the intention to deceive or manipulate**.

MISINFORMATION AND MISCONCEPTIONS

1. **Vaccines Cause the Diseases They Are Meant to Prevent**:

- Fact: Vaccines do not contain active viruses. They stimulate our immune systems to produce antibodies needed to protect against diseases.

2. Vaccines Contain Toxins or Harmful Ingredients:

- Fact: Vaccines undergo rigorous safety testing. The ingredients are carefully selected and monitored.

3. Vaccines Overload the Immune System:

- Fact: Vaccines are designed to stimulate the immune system without overwhelming it.

4 Vaccines Cause Autism (e.g., MMR Vaccine):

- Fact: Numerous studies have debunked any link between vaccines (including MMR) and autism.

MISINFORMATION AND MISCONCEPTIONS

5. **Diseases Were Already Disappearing Due to Hygiene and Sanitation**:

- Fact: vaccines have been instrumental in reducing and eliminating diseases

6. Majority of People Who Get Diseases Have Been Vaccinated:

- Fact: They significantly reduce the risk of severe illness.

7. Vaccines Cause Harmful Side Effects or Death:

- Fact: Serious side effects are extremely rare.

8. Giving Multiple Vaccines Simultaneously Is Risky:

- Fact: Simultaneous vaccination is safe and common practice.

9. **Vaccines (HPV vaccine) cause infertility, make girls to be Promiscuous, depopulation**

Fact: Not true. It is safe and effective against cervical cancer

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SOME STRATEGIES OF MANAGING MISINFORMATION

1. **Prepare**:
    1. Build a team and strategy focused on misinformation management.
    2. Conduct an information ecosystem assessment to understand the context and sources of misinformation
2. **Listen**:
    1. Establish a social listening system to monitor conversations, identify perceptions, and track misinformation.
    2. Create a rumor log to document and analyze false claims or rumors
3. **Understand**:
    1. Assess the misinformation landscape. Understand what false information is circulating and its impact.
    2. Extract actionable insights from your analysis

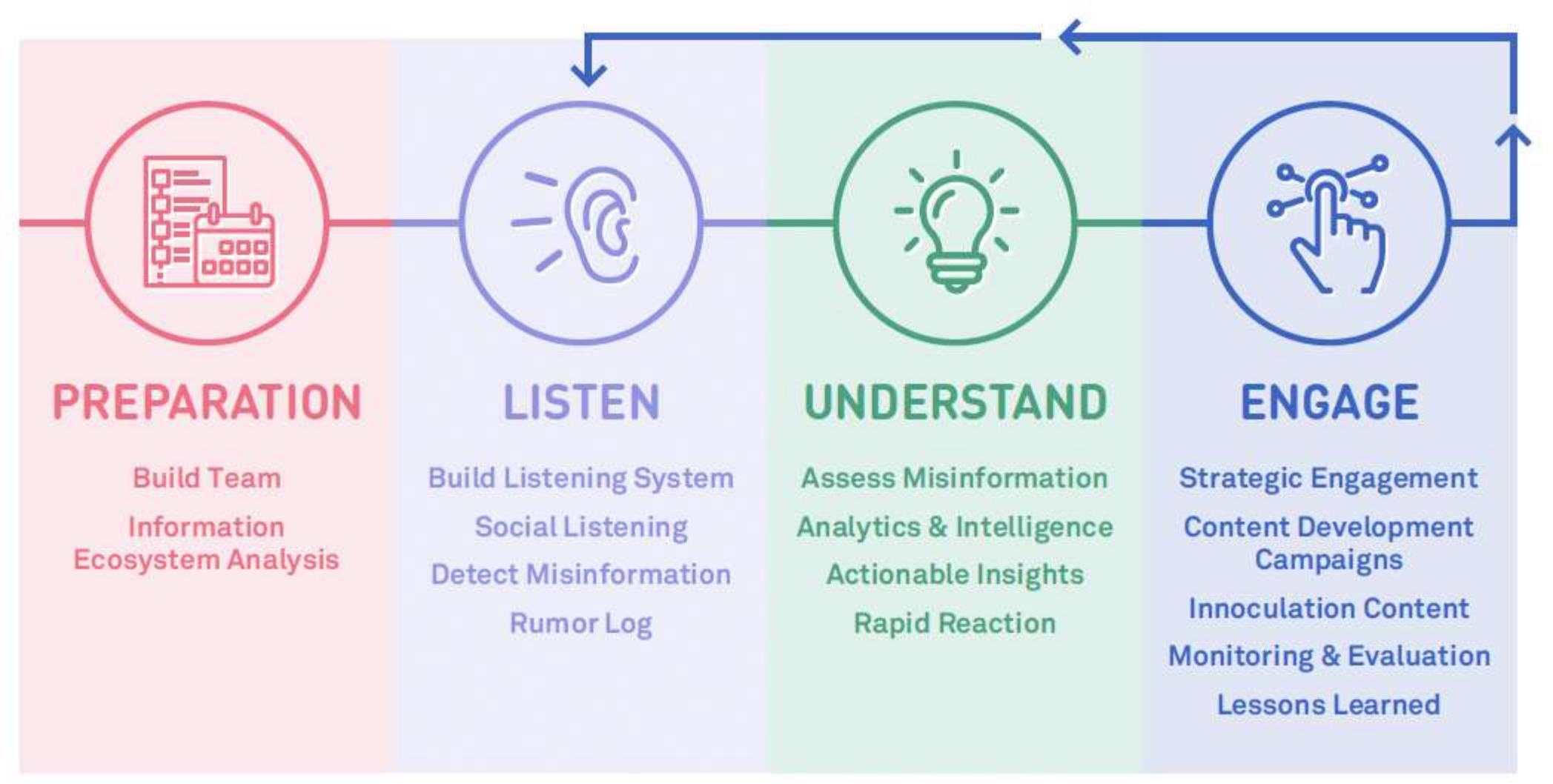
SOME STRATEGIES OF MANAGING MISINFORMATION

4. Engage:

1. Shape the agenda by proactively addressing misinformation.
2. Use prevention strategies:
    1. Provide simple warnings about false claims.
    2. Promote media and health literacy to help people critically evaluate information.
    3. Inoculate (prebunk) by preemptively debunking myths and providing accurate information.
3. Engage trustworthy communicators to amplify accurate messages.
4. Quantify the impact of your efforts.

SOCIAL LISTENING

- What is the parent saying?
- • Why is the parent hesitant?
- • What is happening in the community?
- • What are they saying?
- • Who is saying what?
- • What are they sharing and forwarding?


PREPARATION
Build Team
Information Ecosystem Analysis
LISTEN
Build Listening System
Social Listening
Detect Misinformation
Rumor Log
UNDERSTAND
Assess Misinformation
Analytics & Intelligence
Actionable Insights
Rapid Reaction
ENGAGE
Strategic Engagement
Content Development Campaigns
Innoculation Content
Monitoring & Evaluation
Lessons Learned

Shifting from passive acceptors to a culture of demand

1. Build resilient communities: **educate the next generation of parents**
2. Optimizing the opportunity **health workers** have to influence health-seeking behaviour – vaccinology and communication training
3. Equip media/ press to build trust and spread correct information



CONCLUSION

- Routine immunisation is very important as under-five mortality rate is still high in Nigeria.
- The number of unimmunized children in Nigeria remains high in the country for a variety of factors.
- Routine education of the public is needed to improve the health and survival of children.

- THANK YOU FOR LISTENING

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